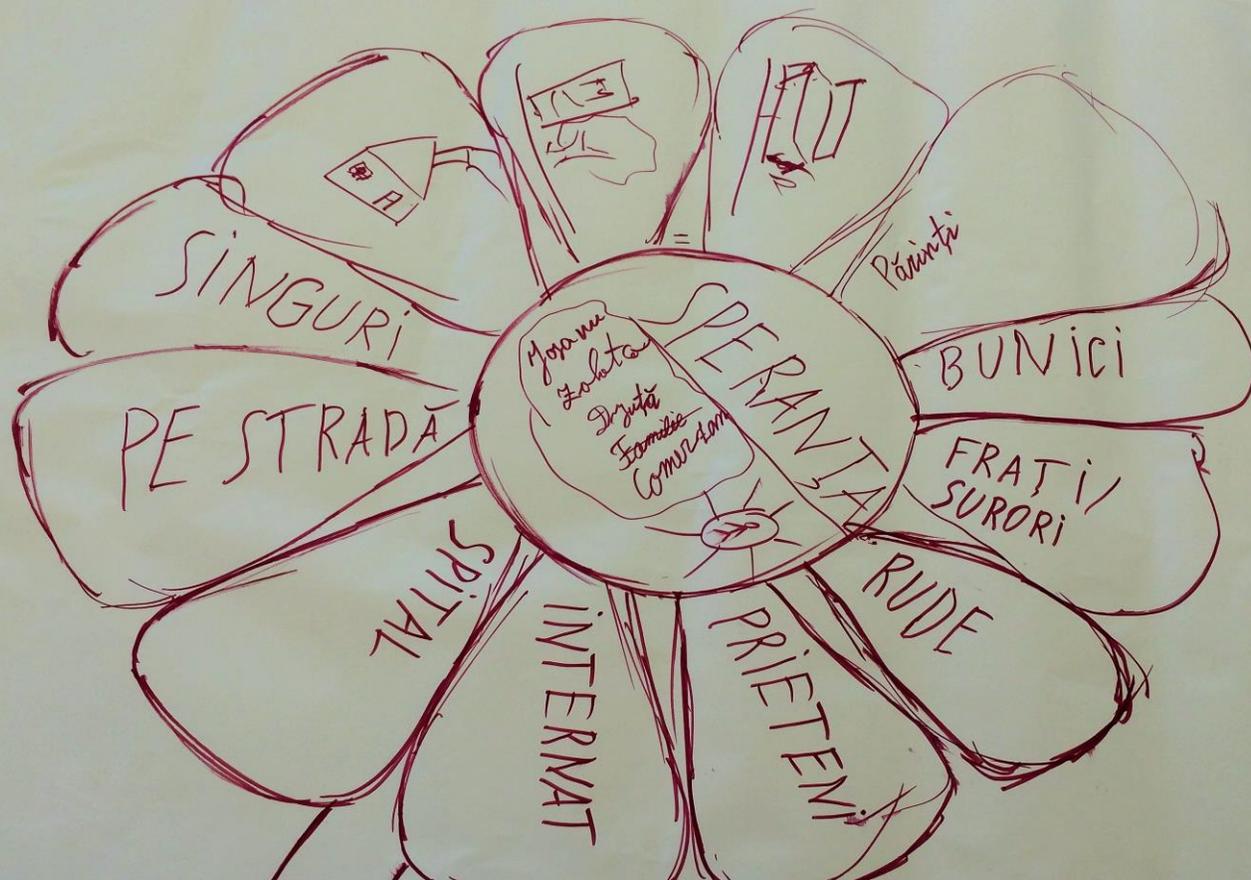




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EVALUATION

Baseline Report Moldova: Performance Evaluation of USAID/DCOF's Children in Moldova are Cared for in Safe and Secure Families Project

October 2015

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Baseline Report Moldova: Performance Evaluation of USAID/DCOF's Children in Moldova are Cared for in Safe and Secure Families Project

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ACRONYMS

ABC	Advisory Boards of Children
APP	Asistenți Parentali Profesioniști (Professional Parental Assistants – Foster Parents)
CCTF	Casa de Copii de Tip Familial (Family Type Children’s Home)
CPCD	Commission for the Protection of the Child in Difficulty
CSAS	Community Social Assistance Service
CSW	Community Social Workers
CSO	Civil Society Organization
DCOF	Displaced Children and Orphans Fund
DFID	Department for International Development
ED	Education Directorate (District government)
EC	European Commission
EvC	EveryChild, UK charity
FGD	Focus Group Discussion
IGACC	International Guidelines for the Alternative Care of Children
IMAS	Institutul de Marketing si Sondaje “IMAS-INC” SRL
INGO	International Non-governmental Organization
IRC	International Rescue Committee
KAP	Knowledge Attitude and Practice
KII	Key Informant Interview
GoM	Government of Moldova
LA	Local Authority
LPA	Local Public Authority
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MLSPF	Ministry of Labor, Social Protection & Family
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non-governmental Organization
OPM	Oxford Policy Management
P4EC	Partnerships for Every Child
PPAS	Psycho-pedagogical Assistance Service
RCC	Residential Care Center
SAFPD	Social Assistance & Family Protection Directorate (District government)
TACIS	Technical Aid to the Commonwealth of Independent States
ToR	Terms of Reference
USAID	U S Agency for International Development
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children’s Fund

EXECUTIVE SUMMARY

USAID's Displaced Children and Orphans Fund (DCOF) provides financial and technical assistance to improve the well-being of children outside of family care or at risk of family separation, through direct interventions that affect children and strengthen human and institutional capacities at the family, community, and national levels. Children are defined as under 18 years of age. USAID/DCOF's overall goal is to measurably improve the safety, well-being, and development of such children. However, DCOF also gives priority to projects that promise impact beyond direct services, which strengthen local capacity, and offer models and approaches for expansion, adaptation, and/or replication.

DCOF has therefore funded the evaluation of a project in Moldova that seeks to ensure that children are in protective and permanent family care by reducing unnecessary separation of children from their families and by placing children who are outside of family care in nurturing families.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The Moldova project *Children in Moldova are Cared for in Safe and Secure Families* is being implemented by Partnership for Every Child (P4EC) from January 1 2014 to June 30 2017. The overall aim of the project is to advance child care reform in Moldova, increasing the shift from institutional care to family-based care. The project is operating at national and local levels, and will work most intensively with 10 raions (districts) in Moldova. The purpose of this baseline report is to establish conditions in the country, particularly in the raions concerned, at the start of program intervention and thus capture improvements when comparing the baseline to midline and endline performance. The evaluation is based on 6 key questions proposed by USAID/DCOF. The first 3 questions deal with successful child reintegration; improving the safety, wellbeing and development of highly vulnerable children; and prevention methods that reduce the risk of child/family separation. The next 3 questions examine if the project has brought about systemic changes in the country that enable children to live in family care and prevent inappropriate placements in institutional care; the sustainability of adequate case-management services for children at risk; and models/approaches for expansion, adaptation and/or replication.

PROJECT BACKGROUND

Even though the percent of children living in residential care has been decreasing – in 2004 the percent of children living in residential care was 0.8% while in 1995 it was 1.2% -- Moldova leads the region in the proportion of children living in residential care. Another 10,000 children (1.3%) are in family-based care. Loss of parental care is caused by several factors including: (1) household poverty; (2) parental migration; (3) violence, abuse and neglect at home, alcohol dependency being a key causal factor; (4) lack of access to good quality education and health care near home; (5) national policies that have historically supported family separation and institutionalization of children (but this has now changed) (6) persistent belief among parents, practitioners and decision makers that the state can care for children better than families.

DCOF previously funded the project *Protecting Children in Moldova from Family Separation, Violence, Abuse, Neglect & Exploitation* from August 2010 – June 2014 (in Ungheni, Calarasi, Falesti, Telenesti and Singerei) which aimed to provide the authorities in Moldova with assistance to strengthen the child protection system, addressing the needs of vulnerable children and their families, and closing the gaps in their access to quality social services, both preventing family separation and protecting children without parental care. The current project *Children in Moldova are Cared for in Safe and Secure Families* builds on the previous work both in the 5 “old” local authorities (LA/raion) and 5 “new” raions which include Soroca, Orhei, Causeni, Cahul and Nisporeni. The focus in the “old” districts is on developing prevention programs for vulnerable families (most of the residential care centers have largely been closed) while the focus in the “new” districts is on closing RCCs and developing alternative family-based care in addition to developing prevention programs.

The project is targeting three groups of children: (1) children living in birth families – supported to stay with their families; (2) children living in residential institutions – transitioning to family and community based care; and (3)

children living in family-based alternatives – supported to reunite with their birth or extended families or placed in adoption. Project stakeholders include (1) those at the national level: Ministry of Labor, Social Protection & Family (MLSPPF), Ministry of Education (MoE), the National Council on Residential Care and Inclusive Education Reform and the National Council for Participation (consists of leading NGOs that advise on legal acts), (2) those at the district level: Local Authorities and the Social Assistance and Family Protection Directorates (SAFPD), and (3) those at the local level: grassroots CSOs involved in service delivery, communities, children, parents, and caregivers.

EVALUATION DESIGN, METHODS AND LIMITATIONS

The evaluation comprises of primary data collected by the NORC team in the form of key informant interviews (KIIs), focus group discussions (FGDs), and a survey of community social workers and specialists of the Social Assistance & Family Protection Directorate (SAFPD)/social work specialists who are the direct beneficiaries of the project; and the use of secondary data collected by P4EC – child wellbeing indicators, a Knowledge Aptitude and Practice (KAP) survey, and capacity building training of stakeholders. NORC drafted and finalized the data collection tools (key informant interview protocols, focus group protocols, and survey questionnaires) for Moldova. These were shared with DCOF and the implementing partner for their feedback prior to finalization.

The quantitative survey (here on called evaluation survey) targeted the community social workers (CSW) and specialists of the SAFPD or “social work specialists” in the 10 project raions for P4EC. NORC included the full sample frame of all male CSWs (there were only a few male CSWs so these were included to make sure that male views were represented) and all the social work specialists in the 10 project raions. Where the total number of CSWs (male and female) was less than 32, NORC included all the CSWs (Calarai (31), Causeni (31), Nisporeni (26), and Singerei (28)). In the remaining 6 project raions we selected a total of 30 CSWs – first including all the males and then randomly selecting among the females. This resulted in a sample of 296 CSWs and 38 social work specialists. When contacted, some of the respondents in the sample were no longer eligible, having left the service and employed elsewhere, giving us a total eligible sample of 311. The total number of actual respondents to the survey was 300 of which 264 were CSWs and 36 social work specialists; 27 males and 273 females.

Qualitative data collection consisted of a series of 29 focus groups led by our subcontractor, IMAS, and 44 KIIs conducted primarily by Subject Area Expert, Beth Bradford. Additional KIIs were conducted by Evaluator Mawadda Damon and Local Coordinator Veronica Pelivan. The team visited six project raions: Soroca, Telenesti, Singerei, Causeni, Ungheni, and Cahul. All interviews and focus groups were recorded where possible. All transcripts were translated into English by IMAS and coded into NVivo by NORC for data analysis.

The Evaluation Team encountered some limitations inherent to the design of this evaluation and during its fieldwork in Moldova. These, however, did not prevent the Evaluation Team from gathering relevant information and data needed to produce findings, and conclusions for this baseline performance evaluation.

FINDINGS AND CONCLUSIONS

Question 1: Have reintegration methods employed by the projects resulted in stable and sustained placements for children?

Findings:

- Perceived increase in the number of children needing alternative care. Participants in both focus groups with social work specialists felt the number of children separated from their biological families is increasing because of greater visibility of these children. Other views of the reason for the perceived increase were: parents are now aware that their children can be cared for by others and they “take advantage of this situation.” According to the focus groups, while the number of children placed in residential centers is decreasing, mayors and specialists are still seeing an increasing number of children needing placement in alternative family-based care such as foster homes, guardianship, and family type children’s homes.

- Deinstitutionalized children continue to face challenges in Moldova. The evaluation survey¹ shows that deinstitutionalized children and their caregivers continue to face challenges in the country. Only 21% of respondents felt that deinstitutionalized children and their caregivers face “no challenges;” 66% felt they did face some sort of challenge. Additionally, 41% felt that children face stigma from the community. All focus groups that discussed the issue also felt that there was at least some sort of adjustment period for children and their caregivers.
- Children with disabilities, those in poor families, and older children face more challenges after deinstitutionalization: Gender does not seem to be a factor in level of adaptation whereas socioeconomic status and age seem to play significant roles. Focus group respondents felt reintegration is more challenging if the child comes from a vulnerable family versus those from “good” families who are in RCCs because their parents had left the country to find work.
- Follow-up social services to families of reintegrated children exist but can be improved. Social workers responded in the survey that they provide several follow-up services to families with reintegrated children. However, the lowest responses were for housing services, employment / household income support, and parent education; confirming the focus group findings above that vulnerable families struggle financially to take care of their reintegrated children and the view that more parental education is needed prior to reintegration.

Conclusions:

- The decrease in the number of children being placed in residential centers has caused an increased need for various forms of alternative care such as foster homes, guardianship, and family type children’s homes.
- Children as well as their caregivers (biological and alternative) continue to face challenges after deinstitutionalization; deinstitutionalized children with disabilities, those in poor families, and older children face more challenges than other types of children.

Question 2: Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? Did the program impact beyond direct services?

Findings:

- Alcoholic parents are a key reason for child separation from their biological families. And lack of employment opportunities and migration is a key factor in increasing the number of children without parental care.
- Guardianship or family care are positively-viewed alternative to staying with biological parents. A large majority of focus group participants who discussed the issue felt that while the best solution is for children to stay in their biological families, when this is not a possibility, it is best to try to find a good placement among relatives – grandparents in particular were mentioned as the best alternative by children and parents.
- RCCs and living with strangers are negatively-viewed alternatives to family care. In focus groups with children, RCCs were the most likely to be mentioned as a negative placement option, since it was felt that RCCs did not provide the love and care that a family provides. Otherwise, a variety of negatively-viewed placements that did not involve relatives, such as with neighbors, foster homes, adopted families, and placement centers, were mentioned by a few focus groups.
- In the FGDs with children, participants were asked to create a flower using the petals to indicate which types of people helped children the most and then they were asked which types of people helped children the least. Non-family members are usually considered as not providing support to children. On the other hand personal relationships and government structures are considered as providing support to children.
- A variety of factors were considered in defining and measuring child wellbeing grouped under health, safety, education, material and psychosocial wellbeing. The data show varying results both within and across RCCs.

Conclusions:

¹ The evaluation survey targeted the community social workers and specialists of the Social Assistance & Family Protection Directorates

- The number of children without parental care is increasing; the main two reasons being alcoholic parents followed by migration due to lack of jobs in the country.
- According to all stakeholders it is best for children to stay with biological parents and in the absence of this possibility, to stay with other relatives. RCCs are viewed as a negative placement by most children, with other negative placements being neighbors, foster homes, adopted families and placement centers.
- Family-based alternative care options are still limited. Guardianship and adoption are largely available in communities, but the availability of family-type children's homes (CCTF), emergency / temporary placement centers, and community group homes is still lacking.

Question 3: Have prevention methods employed by the projects reduced risks of child/family separation?

Findings:

- Vulnerable families need to be able to secure jobs in Moldova. According to focus group respondents, the lack of jobs in Moldova is a key issue for vulnerable families. Key informant respondents reported that children with parents who have migrated to find work are an especially vulnerable group.
- Vulnerable families have difficulty in obtaining sufficient financial assistance. While poverty and lack of money to provide the necessary conditions to care for children is a common issue among vulnerable families, all of the focus groups with parents mentioned how challenging it is to actually receive social assistance
- According to the focus group respondents, important factors to preventing the separation of children from their families are early intervention and prevention services such as emergency services, services for mother-child, and more diverse services such as other kinds of foster care in addition to education and support of parents or future parents.
- According to evaluation survey respondents, the most commonly available services to support vulnerable families are social assistance, case management, housing assistance services, public schooling, and kindergartens. Services that are the least available are substance use/abuse services, job skills training programs for adults, and juvenile delinquency prevention programs.
- About two-thirds of evaluation survey respondents, both social service specialists at the raison level and community social workers at the community level responded that services are "somewhat adequate" to meet the needs of families to help ensure that children can stay in or be returned to family care. Most families are able to access services, but there remains a lack of availability of a wide range of services at the community level.
- Social workers, through self-assessment, believe they are effective in family strengthening and stabilization.

Conclusions:

- Vulnerable families suffer from a lack of jobs in Moldova and find it difficult to have enough finances to stay in the country to care for their children instead of leaving their children behind and migrating to find work. While social assistance is widely available, it is difficult to access and is not felt to be sufficient to cover their needs.
- There aren't enough child care services at the community level, such as before and after school programs and day care, to allow parents to work full time.
- On average, child care and protection services were rated as only somewhat adequate and family support services as only somewhat effective at improving caregiving. However, respondents did feel that the system was very effective at strengthening and stabilizing families.
- Parents are not able to maintain a steady job because they need to care for their disabled children and the social assistance provided is not enough to allow them to stay at home to provide the care. Moreover, services for children with disabilities are not widely available across communities and need improvement.
- Substance use/abuse is a major issue among families and the existing services are not meeting the needs because they are not widely available or effective.
- Early intervention and prevention services such as emergency services, services for mother-child, diverse services such as other kinds of foster care, and parental education were viewed as very important to ensuring children remain in their families.

Question 4: Did the program bring out systemic changes at the community, regional, and national levels that are enabling children to live in family care and preventing inappropriate placements in institutional care?

Findings:

- Social workers believe that existing national policies and legislation are being adequately implemented to support the functioning of the child protection system. In the key informant interviews, the policies most frequently mentioned as important were the Inter-Sector Cooperation Mechanism, Law 140, Law on Social Assistance, National Strategy for Child Protection, National Strategy on Restructuring the Residential System, and the National Strategy for Inclusive Education.
- Individual one-on-one parenting education with a social worker is most effective at improving parenting skills, followed by parenting classes/workshops and support groups. Written resources are considered as the least effective methods for increasing parenting skills and knowledge.
- According to the results of the evaluation survey, there is still widespread acceptance of residential care facilities. Focus group participants indicated that views on the appropriateness of placing a child in an RCC have changed. Previously, if a child was separated from his/her parents for any reason (e.g., death) the child was placed in a RCC, even if there were relatives willing to take him/her in. Now they take the opposite approach and try to find a solution within a family. On the other hand, in cases of children with severe mental disability, many of those from within the child care and protection system felt that it was best for them to be placed in an RCC.
- Only some parents believe RCCs are acceptable for their children, and the majority of focus group respondents felt that RCCs are not a positive place for children.
- There are negative stereotypes of children in RCCs. Some common perceptions of children in RCCs reported in focus groups are: they don't have a good upbringing and have behavior problems such as smoking, abusing drugs, drinking, and spending time at the disco; they are uneducated or less intelligent; and they have some type of illness. Other perceptions are that they are poor, beaten, and commit crimes, they are tormented at the RCCs and made to do hard work; or they are sad and closed off from people.
- Children from RCCs face challenges when integrating into public schools. In focus groups parents mentioned difficulties in children from RCCs performing well at public school since it has a more difficult curriculum than RCCs. According to focus group respondents, it is believed that children with mental disabilities should not be integrated into public schools because they are not able to function at the same level as the other children and will be isolated. However, one focus group felt that it is possible to integrate children with physical disabilities if done at an early age.
- Children play a limited role in placement decision making. According to focus group respondents, social workers are the main players regarding placement of a child. Others involved in the decision-making are parents and other relatives. In some cases, the child may be asked his/her opinion if he/she is over 14.
- A particular message of a few focus groups is that children of any age should be consulted with and listened to. According to focus group respondents, the Advisory Boards of Children (ABCs) play an important role in having the child's perspective and voice heard. Their mandate is to monitor and defend children's rights. They collaborate with community social workers and conduct home visits.

Conclusions:

- Community social workers and social work specialists believe that existing national policies and legislation are being adequately implemented to support the functioning of the child protection system.
- Individual one-on-one parenting education with a social worker are considered most effective at improving parenting skills.
- RCCs are viewed as an acceptable form of care for children by social workers in cases when the child is orphaned or when the child has a severe mental disability.
- Children in RCCs suffer from negative stereotypes, and face challenges when integrating into public schools.
- It is believed that children with mental disabilities should not be integrated into public schools because they are not able to function at the same level as the other children and will be isolated. Those with severe mental disabilities should attend special day schools and their parents should be trained so that they can continue to be cared for in their families instead of being sent to an RCC.

- Children play a limited role in placement decision-making. Some people felt children may be asked their opinion about placement if they are over 14 while others thought children are not asked their opinion at all. In either scenario, the child's opinion does not play central role in placement decision making.

Question 5: By project end, to what extent have functioning structures been established that can continue to provide on an ongoing basis adequate case-management services for children at risk?

Findings:

- Awareness and support for child protection services at the raion level. A majority of the evaluation survey respondents, 64%, strongly agreed that the raional council is aware of national child protection policies. Focus groups with mayors, social work specialists, and community social workers showed that they were all very familiar with Law 140, the mayors in particular cited the law and were familiar with the associated procedures involving the multidisciplinary teams.
- Existing structures are effective in child protection. Gatekeeping commissions are viewed as being most effective (71% "strongly agree"), while raion and community structures are seen by social workers as effective, but less strongly so.
- Social workers are comfortable with their skills and aware of job responsibilities. While 88% of social workers said that they understand the role and responsibilities of their job, only about two thirds felt supported in their job (65%), and felt that their supervisor provides support that helps them do a better job (69%).
- The KAP survey undertaken by P4EC shows that community social workers have varied knowledge regarding protection measures to follow after identifying a case of abuse or maltreatment of children. Those in Falesti, Soroca, Ungheni, and Singerei were able to identify appropriate measures (referral, collaboration with the mutli-disciplinary team, opening a case file, case management procedures, development of the individual assistance plan, removal of the child from the family if he/she is found to be at high risk, working with leading specialist in the CSAS, etc.). However, community social workers from Causeni, Nisporeni, Calarasi, Orhei and Telenesti showed some gaps in their knowledge. There was also mixed knowledge among social workers regarding how professionals from education, health and police can help prevent and intervene in the cases of abuse.
- According to survey respondents they have fewer logistical/financial resources relative to professional resources. This was confirmed by the focus groups. Three out of the 4 focus groups with community social workers mentioned the issue of not having a space in which to operate and receive families and three spoke of the lack of funds to finance specialists. Focus groups with social work specialists highlighted that they receive a lot of training but what is missing is joint training of the multidisciplinary teams.
- Multidisciplinary teams (currently being trained under the project) were mentioned by almost all stakeholders among key informants interviewed as an important new actor in community-level child protection. Focus group respondents viewed multidisciplinary teams very positively as a means to engage all members of the community to work together from different perspectives to protect and care for children.

Conclusions:

- A majority of stakeholders feel that there is awareness and support for child protection services at the raion level. Almost all respondents say that their raion has a child protection service development strategy.
- Majority of CSW and social work specialists feel that existing raional and community structures and the Gatekeeping Commissions are effective in child protection. The complexity of family situations are also not considered to be a hindrance affecting the child protection work of social workers.
- Social workers understand their job roles and responsibilities. Most feel supported by their supervisors, especially with respect to the availability of professional resources. Less are satisfied with the financial/logistical resources.
- Community social workers have varied knowledge regarding protection measures to follow after identifying a case of abuse or maltreatment of children and how professionals from education, health and police can help prevent and intervene in the cases of abuse.
- While cooperation and collaboration among raional stakeholders and multidisciplinary teams is considered to be high, some felt that it was less among the national and raion government. There were some criticisms regarding the smooth functioning of the multidisciplinary teams.

Question 6: Did the project offer models and approaches for expansion, adaptation, and/or replication?

Since this evaluation question deals with project specific models and approaches and issues of sustainability we will present findings for this question only in the midline and endline evaluation reports.

I.0 EVALUATION PURPOSE & EVALUATION QUESTIONS

I.1 EVALUATION PURPOSE

USAID’s Displaced Children and Orphans Fund (DCOF) provides financial and technical assistance to improve the well-being of children outside of family care or at risk of family separation, especially vulnerable children (defined as under 18 years of age) through direct interventions that affect children and strengthen human and institutional capacities at the family, community, and national levels. Children are defined as under 18 years of age. DCOF’s overall goal is to measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care. However, DCOF also gives priority to projects that promise impact beyond direct services, which strengthen local capacity, and offer models and approaches for expansion, adaptation, and/or replication.

USAID/DCOF attempts to ensure that all funded activities build upon and contribute to the knowledge base of evidence concerning the most appropriate practices for ensuring appropriate care, protection, and development of children. It has therefore funded the evaluation of two projects (in Moldova and Burundi) that seek to ensure that children are in protective and permanent family care by reducing unnecessary separation of children from their families and by placing children who are outside of family care in nurturing families. The project in Moldova (*Children in Moldova are Cared for in Safe and Secure Families*) is being implemented by Partnership for Every Child (P4EC), and the project in Burundi (*Family Care First: A Project to Ensure Children in Burundi are Place in Protective and Permanent Family Care*) is being implemented by the International Rescue Committee (IRC). Baseline, midline and endline evaluations will be undertaken for both these projects. This report is the baseline evaluation for Moldova; a similar report was also prepared for Burundi.

The Moldova project is being implemented from January 1 2014 to June 30 2017. The overall aim of the project is to advance child care reform in Moldova, increasing the shift from institutional care to family based care. The project is operating at national and local levels, and will work most intensively with the local authorities (LA) of 10 raions (Romanian term for districts) in Moldova. The purpose of the baseline report is to measure conditions in the country at the start of program intervention and thus capture improvements when comparing the baseline to midline and endline performance. However, since this is a performance evaluation (an evaluation without a comparison group), the report does not attempt to attribute causality between project interventions and results observed in the country.

I.2 EVALUATION QUESTIONS

The evaluation is based on 6 key questions proposed by USAID/DCOF.² Additional sub-questions and indicators proposed by NORC for this evaluation are shown in Annex II: Evaluation Questions and Indicators.

- I. Have reintegration methods employed by the projects resulted in stable and sustained placements for children?

² The Concept Note/Scope of Work for this evaluation is provided in Annex I.

2. Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? Did the program impact beyond direct services?
3. Have prevention methods employed by the projects reduced risks of child/family separation?
4. Did the program bring out systemic changes at the community, regional, and national levels that are enabling children to live in family care and preventing inappropriate placements in institutional care?
5. By project end, to what extent have functioning structures been established that can continue to provide on an ongoing basis adequate case-management services for children at risk?
6. Did the project offer models and approaches for expansion, adaptation, and/or replication?

Since this is the baseline report we only present the findings and conclusions, as it is too early to provide recommendations, for evaluation questions 1 through 5; evaluation question 6 will be addressed in the mid- and endline reports.

2.0 PROJECT BACKGROUND

2.1 MOLDOVA PROGRAM CONTEXT

The Republic of Moldova (hereafter Moldova) became independent from the Soviet Union in 1991, inheriting a child welfare system heavily reliant on institutional care for the protection for vulnerable children. A population of 3.56 million (2013) live in 32 raions and 2 autonomous republics. Moldova is the poorest country in Europe with 17% of the population living below the poverty line and many families struggling to care for their children. Approximately 58% of the population lives in rural areas where lack of employment and limited access to social protection services further exacerbate poverty-related issues.³

Even though the percent of children living in residential care has been decreasing – in 2004 the percent of children living in residential care was 0.8% while in 1995 it was 1.2% -- Moldova leads the region in the proportion of children living in residential care. Another 10,000 children (1.3%) are in family-based care. Loss of parental care is caused by several factors including⁴:

- Household poverty (Moldova is the poorest country in Europe);
- Parental migration, with 1 in 4 children having at least one parent living or working abroad;
- Violence, abuse and neglect at home - alcohol dependency being one key causal factor;
- Lack of access to good quality education and health care near home; and
- The persistent belief among parents, practitioners and decision makers that the state can care for children better than families.

USAID/DCOF previously funded the project *Protecting Children in Moldova from Family Separation, Violence, Abuse, Neglect & Exploitation* from August 2010 – June 2014 implemented by Every Child (EvC). EvC Moldova was established in 2003 and later supported the establishment of Partnerships for Every Child (P4EC), a Moldovan firm which started operations in April 2012.

The previous project aimed to provide the authorities in Moldova (at the national, regional and local levels) with assistance to strengthen the child protection system, addressing the needs of vulnerable children and their families, and closing the gaps in their access to quality social services, both preventing family separation and protecting children without parental care. Three regions were targeted by the USAID project – Ungheni, Calarasi, and Falesti. The project was expanded into Telenesti and Singerei with the support of Every Child UK and a private donor. The current project *Children in Moldova are Cared for in Safe and Secure Families* builds on the previous work both in the 5 “old” raions and 5 “new” raions which include Soroca, Orhei, Causeni, Cahul and Nisporeni. After the start of the current project, a sixth “new” raion, Rezina, was added at the request of the Ministry of Education and upon approval by USAID.⁵ Among the new components of the current project are those related to prevention such as the Strengthening Families Program, inter-agency work on the basis of child wellbeing

³ From “Protecting children in Moldova from family separation, violence, abuse, neglect & exploitation: Final Evaluation Report.” By N. Beth Bradford. August 1, 2014. Chisinau, Moldova: Partnership for Every Child.

⁴ From “Children’s Reintegration. Longitudinal Study of Children’s Reintegration in Moldova.” By Dr. Helen Banös Smith. February 2014. Chisinau, Moldova: Family for Every Child and Partnership for Every Child.

⁵ P4EC is not implementing all project activities in this raion – the focus is on deinstitutionalization. As a result, it was agreed that only data on deinstitutionalization in Rezina, gathered by P4EC, would be included in this evaluation.

indicators, and Psychosocial Support Program for Children, as well as strengthening and diversification of alternative care for children.

2.2 MOLDOVA PROGRAM OBJECTIVES

The overall objectives of the project are:

1. Across Moldova, 100,000 children who are at risk of losing family care, are living with seriously inadequate family care, or are outside family care have increased chances to stay with their strengthened families or be placed in appropriate, protective, and permanent alternative family care;
2. 4,000 children have been prevented from being unnecessarily separated from their families in 10 regions of Moldova;
3. 3,000 children who are outside family care in 5 regions of Moldova live in safe and nurturing families.

The project is targeting three groups of children:

- Children living in birth families – supported to stay with their families
- Children living in residential institutions – transitioning to family and community-based care
- Children living in family-based alternatives – supported to reunite with their birth or extended families if possible or placed in adoption

2.3 MOLDOVA PROGRAM DESIGN AND MANAGEMENT

The 10 project districts are at varying levels of development regarding their child care and protection systems.⁶ The residential care centers (RCCs) have largely been closed in the five “old” raions where P4EC previously worked during their prior project. Table 2.1 below details their status, indicating whether it is an “old” or “new” raion and the level of development from low to high.

Table 2.1: Level of development of child care and protection system by project raion

Raion name	Level of Development of Child Care and Protection System			
	Low	Medium	High-Medium	High
Falesti				Old
Ungehni				Old
Calarasi			Old	
Telenesti			Old	
Singerei	Old			
Orhei			New	
Cahul		New		
Soroca		New		
Causeni	New			
Nisporeni	New			

Source: P4EC Project Director

⁶ As noted above, the 11th raion, Rezina, is only included when reporting deinstitutionalization numbers from the P4EC monitoring data.

The focus in the “old” raions is on developing prevention programs for vulnerable families and testing new approaches and models of practice before replication to all raions. The initial focus in the “new” raions is on closing RCCs and developing alternative family-based care, although by project end, the “new” raions will have received the full package of project activities.

The main activities of the project are as follows⁷:

Objective 1

- Build capacity of the Ministry of Labor, Social Protection and Family (MLSPF) and Ministry of Education (MoE) to implement the National Child and Family Protection Strategy, amend child care legislation, and develop the Child Participation Policy; improve communication (develop common vision on child care reform and communicate this campaign to the public); and improve monitoring and evaluation (M&E) framework to monitor children and vulnerable families;
- Support MLSPF to train the national workforce of community child protection specialists (to be recruited) and social workers to provide services in line with new legislation; gatekeeping commissions on revised regulations to prevent child separation; raion local authorities on inter-agency collaboration on prevention and child protection; and community multidisciplinary teams to work on prevention;
- Facilitate the government’s alliances with civil society organizations (CSOs), including faith-based, academia, practitioners;
- Support 10 districts to develop communication plans and tools.

Objective 2

- Support 10 raions to develop a holistic model for family strengthening and preservation; train family support teams, community social workers, and child protection specialists to provide primary and secondary family support; train foster care teams, community social workers, and child protection specialists to provide and support short-break foster care placements for children with disabilities living in families; and revise membership of and train gatekeeping commissions.
- Support five “old” raions to plan, deliver, and evaluate a Strengthening Families Program and Psychosocial Support Program for Children.

Objective 3

- Support 7 raions to shift alternative care toward permanent family-based care and assess, plan, and reorganize residential institutions;
- Support 5 raions to build capacities of community social workers to plan, implement, and monitor individual plans for deinstitutionalization of children and to develop short-break, emergency, short-term and long-term foster care;
- Train and support 10 raions to develop inclusive education at district and school level;
- Build capacities of 10 raions to put in place sound child participation policies and practices.

⁷ Adapted from P4EC quarterly project reports.

Project stakeholders include (1) those at the national level: MLSPF, MoE, the National Council on Residential Care and Inclusive Education Reform and the National Council for Participation (consists of leading non-governmental organizations (NGOs) that advise on legal acts); (2) those at the district level: Local Authorities, the Social Assistance and Family Protection Directorates (SAFPD), and gatekeeping commissions; and (3) those at the local level: mayors, multidisciplinary teams, community social workers, grassroots CSOs involved in service delivery, communities, children, parents, and caregivers.

P4EC has compiled a team of 23 key staff including a Director, Project Team Leader, Child Participation Specialist, Public Finance Reform Specialist, Training Manager (also in charge of academic collaboration), 5 Coordinators, 2 staff working on communications and PR, and 2 staff responsible for collaboration with NGOs and churches. Additionally, P4EC has subcontracted with Terre des Hommes to implement initial trainings of the multidisciplinary teams.

3.0 EVALUATION METHODS & LIMITATIONS⁸

To gather data required for this evaluation, NORC's Evaluation Team used several techniques which entailed a mix of mutually reinforcing qualitative and quantitative methods that reflect the program design, research questions being addressed, and indicators. We combined the results of each technique to capture the diversity of opinions and perceptions of beneficiaries and stakeholders about key children/family care and protection issues at the start of the program. The qualitative analysis, which includes a document review, key informant interviews (KII) and focus group discussions (FGD), provides the local context and also represents concrete examples that illustrate in greater detail the quantitative findings. Our approach to selecting the appropriate methodology is based on the USAID Evaluation Policy as well as our experience conducting evaluations in the field.

The NORC Evaluation Team conducted the evaluation in a participatory manner which involved engaging USAID/DCOF, implementing partner P4EC, program beneficiaries, and other stakeholders. A complete list of documents the Evaluation Team reviewed is included in Annex V, Sources of Information.

3.1 EVALUATION MANAGEMENT

The evaluation team for Moldova includes Ritu Nayyar-Stone (Project Director), Mawadda Damon Gartner (Evaluator), N. Beth Bradford (Subject Area Expert) and Huyen Le (Research Analyst). Veronica Pelivan (Local Coordinator) provided logistical support, took notes during KIIs, and led KIIs in two raions. Local data collection was undertaken by Institutul de Marketing si Sondaje "IMAS-INC" SRL (IMAS) who conducted the FGDs and administered the evaluation survey. As a measure to ensure high data quality, NORC provided targeted training to IMAS for FGDs and survey administration/quality control; undertook a data quality review of the received data; and did all the analysis.

3.2 STUDY DESIGN

The evaluation employs a pre-post design, comparing key indicators and findings for project beneficiaries at baseline to those at endline. This approach allows us to understand changes over time but does not allow us to attribute these changes to the project intervention since it was not possible to include a comparison group. At endline we will also examine the possibility of model based analysis.

Concerns about confidentiality and sensitivity in contacting vulnerable children and their families directly, as well as the fact that children and families are indirectly beneficiaries of the P4EC project, led to a change in the target population for the evaluation survey. NORC had originally planned to survey caregivers of children in vulnerable families, but after consultation with P4EC and agreement by USAID/DCOF, a questionnaire was designed for social workers. This change in study design required NORC to depend solely on P4EC to obtain information on the wellbeing of children (i) currently in RCCs and (ii) in vulnerable families, due to concerns about evaluators being in direct contact with this vulnerable population. NORC and P4EC worked closely together to develop indicators of child

⁸ More details on Evaluation Methods and Limitations are provided in Annex III.

wellbeing (see Annex II), and P4EC built the capacity of and assisted social workers in obtaining child wellbeing information for both vulnerable children at home and vulnerable children currently in RCCs.

The evaluation therefore comprises of primary data collected by the NORC team in the form of KIs, FGDs, and a survey of community social workers and social work specialists of the SAFPD, who are the direct beneficiaries of the project; and secondary data collected by P4EC – child wellbeing indicators, a Knowledge, Attitude, and Practice (KAP) survey, and monitoring data of capacity building training of stakeholders.

NORC drafted and finalized the data collection tools (key informant interview protocols, focus group protocols, and survey questionnaires) for Moldova. These were shared with USAID/DCOF and the implementing partner for their feedback prior to finalization. The tablet-based survey was programmed by IMAS and tested by both IMAS and NORC prior to beginning enumerator training. NORC developed all training materials and Evaluator Mawadda Damon and Subject Area Expert Beth Bradford traveled to Moldova from 02/18-27/2015 to conduct the training for FGD and survey enumerators and do some KIs with P4EC staff and other stakeholders.

3.3 TARGET POPULATION

The quantitative survey (here on called the “evaluation survey”) targeted the CSW and specialists of the SAFPD or “social work specialists” in the 10 project raions for P4EC.

Qualitative data collection consisted of a series of 29 focus group discussions led by our subcontractor, IMAS, and 42 key informant interviews conducted primarily by Subject Area Expert Beth Bradford. Additional key informant interviews were conducted by Evaluator Mawadda Damon and Local Coordinator Veronica Pelivan. The key informant interview team interviewed the P4EC project team and key national stakeholders such as representatives of the Department of Mother and Child at the Ministry of Education, Department of Pre-University Education at the Department of Education, and the Faculty of Social Work at Moldova State University. Additionally, Beth Bradford and Veronica Pelivan visited six project raions: Sorooca, Telenesti, Singerei, Causeni, Ungheni, and Cahul where they interviewed the Vice Presidents on Social Issues, Heads of Social Assistance and Family Protection, Child and Family Protection Specialists, Heads of Education Departments, and Heads of Community Social Assistance Services in the SAFPDs and Heads of RCCs where they existed. All interviews and focus groups were recorded where consent was obtained and largely conducted in Romanian. All FGD transcripts were translated into English by IMAS and coded in NVivo by NORC for data analysis.

Focus groups were conducted with the following raion or community-level stakeholders. At the raion-level are the social worker specialists (those working at the SAFPD such as the Child Rights Protection Specialist, Family Protection Specialist, Head of Community Social Assistance service, Foster Care Manager, Manager of the Community Social Assistance Service, and Social Worker Coordinators (of services such as adoption, family-type children’s homes, guardianship (kinship care), family support, and community centers), and gatekeeping commissions (mix of professionals from schools, police, social workers and health providers who review child cases). At the community-level are the community social workers, multidisciplinary teams (mix of professionals including mayors, teachers, police, social workers, and health providers who review child cases), mayors, advisory boards of children (ABCs), girls, boys, and parents.

Table 3.1: Number and location of focus group discussions

Target	# FGDs	# Participants	# Male	# Female	Districts represented*
Community social workers	4	35	4	31	Causeni, Falesti, Singerei, Soroca, Ungheni
Social worker specialists	2	15	0	15	Calarasi, Falesti, Nisporeni, Orhei, Ungheni
Multidisciplinary Teams	2	16	4	12	Cahul, Singerei
Gatekeeping Commissions	2	14	4	10	Calarasi, Falesti, Nisporeni, Orhei, Ungheni
Mayors	3	18	16	2	Falesti, Nisporeni, Soroca, Ungheni
ABC	2	15	2	13	Cahul, Calarasi
Girls	4	34	0	34	
Aged 12 -14	2	19	0	19	Falesti, Soroca
Aged 15-17	2	15	0	15	Causeni, Orhei
Boys	4	32	32	0	
Aged 12 -14	2	19	19	0	Nisporeni, Telenesti
Aged 15-17	2	13	13	0	Singerei, Ungheni
Parents	6	46	1	45	
At-risk children	2	16	0	16	Cahul, Singerei
Deinstitutionalized children	2	13	1	12	Orhei, Ungheni
Children in RCC	2	17	0	17	Nisporeni, Soroca
Total	29	225	63	162	

3.4 SAMPLING

NORC included the full sample frame of all male CSWs and all the social work specialists in the 10 project raions. Where the total number of CSWs (male and female) was less than 32 NORC included all the CSWs (Calarai (31), Causeni (31), Nisporeni (26), and Singerei (28)). In the remaining 6 project raions we selected a total of 30 CSWs – first including all the males and then randomly selecting among the females. This resulted in a sample of 296 CSWs and 38 social work specialists. When contacted, some of the respondents in the sample were no longer eligible, having left the service and employed elsewhere; giving us a total eligible sample of 311. The total number of actual respondents to the survey was 300 of which 264 were CSWs and 36 social work specialists.

FGD locations were chosen to represent the diversity of different raions so that each target group had representatives from the “old” and “new” raions; raions of low, medium/medium-high, and high level of development of child care and protection systems; and, to the extent possible given the other two criteria and limited total number of FGDs, northern, central, and southern raions.

Raions where the KIIs were conducted were chosen to include a range of low, medium/medium high, and high levels of child care and protection system development, regional diversity, and to avoid those raions with which the Subject Area Expert, Beth Bradford, was already quite familiar due to past evaluation work.

3.5 LIMITATIONS

The Evaluation Team encountered some limitations inherent to the design of this evaluation and during its fieldwork in Moldova. Some of the more relevant limitations are listed below:

- **Reluctance to respond to survey.** The data collection team faced reluctance from CSWs and social work specialists to participate in the surveys. Despite our messaging to the contrary,

word of the survey was circulated among social workers in regions where our team had not yet arrived, along with the wrong perception that it was a test of their knowledge, and thus their heads of department started to put up barriers to the data collection such as insisting on being present for each interview. Our local data collection firm, IMAS, worked hard to correct this false information and convince the heads of the department and social workers that we are evaluating the program and not them, which they eventually managed to do, obtaining a 96% response rate.

- **Baseline timeframe.** The program started in January 2014, but NORC's concept note for the evaluation was approved by mid-June 2014; the evaluation design was completed by December 2014; and the data collection was undertaken in March-April 2015. Thus some program implementation such as training and capacity building of stakeholders had already started prior to the baseline which may have influenced their feedback and response.
- **Administrative and M&E data from the implementer.** P4EC has been conscientious regarding data collection, making great efforts to work with the CSWs to collect important data on child demographics, wellbeing, family status, etc. However, lack of sufficient CSW skills in following rigorous data quality assurance practices resulted in too few observations for certain indicators and inconsistency across districts, sometimes making the data unusable for analytic purposes.⁹ This baseline evaluation only include information from administrative data on children in RCCs; we were unable to use the data on vulnerable children and families. The above limitations, however, did not prevent the Evaluation Team from gathering relevant information and data needed to produce findings, and conclusions for this baseline performance evaluation.

⁹ NORC has already has discussions with P4EC regarding this and shared a sample template for data collection moving forward. We plan to have more detailed conversations with their team to follow-up on this so that data collected in the future can be used for analytical purposes.

4.0 FINDINGS, CONCLUSIONS & RECOMMENDATIONS

In this section we summarize the findings and conclusions from the quantitative, qualitative and administrative baseline data collection. For each evaluation question NORC developed a series of sub-questions to help with the analysis and obtain targeted feedback to inform the overarching evaluation questions. We list the sub-questions under each evaluation question but have a broad discussion of findings by the overarching evaluation question only. The pre-post evaluation design will allow us to understand changes over time. NORCs concept paper for this evaluation (see Annex I) also includes using model based approaches where each observational unit (e.g., well-being of children in institutional care, or vulnerable children) can be used to contribute to our understanding of project results by allowing us to infer whether differences in the amount of program interventions can “explain” variation in (impacts on) performance once country-specific factors are taken into account. Since this is a baseline report analyzing current conditions and perceptions, we will revisit the possibility of model-based analysis when we examine project performance at endline. Currently we have done a few chi-squared tests to examine independence or correlation between various responses/variables in the survey that examine issues under evaluation questions 2, 4, and 5.

Question 1: Have reintegration methods employed by the projects resulted in stable and sustained placements for children?

Sub-questions:

- a) Are increased number of children living in residential care facilities being placed in family care?
- b) During the tracing process, what percentage of children in residential care have been identified a birth family or kinship care option that is safe and appropriate?
- c) What factors prevented placement of children in residential care into permanent family care?
- d) What type of social service follow-up is provided to deinstitutionalized children, by whom and for how long?

Findings:

Perceived increase in the number of children needing alternative care: Participants in both focus groups with social work specialists felt the number of children separated from their biological families is increasing because of greater visibility of these children - local authorities and professionals are more informed and aware of cases of children living in their biological families without adequate care, so it seems as if the number of these children is increasing (2 focus groups with social work specialists). Another commonly held view on the reason for the perceived increase is continued lack of jobs that drives parents to immigrate to find a job (3 focus groups with community social workers, social work specialists, and mayors). Other views of the reason for the perceived increase were: parents are now aware that their children can be cared for by others and they “take advantage of this situation” (focus group with community social workers) and greater empowerment of children and knowledge of their rights (focus group with mayors).

According to the focus groups, while the number of children placed in residential centers is decreasing, mayors and specialists are still seeing an increasing number of children needing placement in alternative

family-based care such as foster homes, guardianship, and family type children’s homes (6 focus groups with community social assistants, social work specialists, multidisciplinary teams, and mayors).

“[The number of children without parental care] is increasing because the system works well. Before persons were less informed and less aware, now instead the neighbors, local public administration collaborates, and overall population is aware of these situations. [We should look at] residential institutions which were closed 4 years ago and now no children are placed in these institutions and the number of children placed in foster homes is growing. The same thing is with guardianship, APP [foster care] and CCTF [family-type children’s homes] because children yearly come and go. Ideally the number should be stable or even better should decrease but currently the number is increasing.” (Female social work specialist from focus group with participants from Falesti and Ungheni)

There were a few respondents who felt the number of children in alternative care is decreasing due to reintegration (focus group with social work specialists) or the change in Russian policies that made it more difficult for parents to immigrate to Russia to find jobs (focus group with community social workers in Soroca). A few community social workers believe that the number of children not cared for by their parents has remained the same. They believe that it is the same families that leave their children and this type of behavior is perpetuated over the generations within the same families (focus group with community social workers).

Gender difference and disability evident in Project RCCs: P4EC is currently working with 5 RCCs across the 10 project districts¹⁰. Of the total number of 236 children in 4 RCCs¹¹, there tend to be more boys (121) than girls (115). As seen in Table 4.1.1 below, the only RCC where the number of girls (43) is more than the number of boys (17) is Ciniseuti.

Table 4.1.1: Number of Children by Gender across Project RCCs

Children in RCC's	Cahul	Ciniseuti	Hirbovat	Nisporeni	Total
Male	33	18	45	24	121
Female	25	43	31	17	115
Total	58	61	76	41	236

Source: P4EC administrative data on children in RCCs

The RCCs in Cahul and Hirbovat are for deaf children, those in Nisporeni and Soroca are auxiliary schools for children with learning difficulties, and the RCC in Ciniseuti is for children with neurological diseases. Table 4.1.2 shows that of the 4 RCCs analyzed, nearly all the children in Cahul and Hirbovat RCCs have some form of physical, cognitive, or sensory disability and the majority of children at the Nisporeni RCC (78%) have learning difficulties. The RCC in Ciniseuti is the only one where the majority of the children are without health or disability issues (78%). Since the sizes of the RCCs vary, the last column in table 4.1.2 gives a more comprehensive assessment of children across all project RCCs. Among all of the children across 4 RCCs, 46% have a physical, cognitive, or sensory disability and 11% experience some form of learning difficulty.

¹⁰ RCCs in Cahul (58 children); Ciniseuti/Rezina (60 children); Hirbovat/Calarasi (76 children), Nisporeni (42 children) and Soroca (41 children).

¹¹ There were problems in the data file for one of the RCCs and thus we were unable to include information from Soroca in time for the baseline analysis. The total number of children across 5 RCCs is 279, but we present information for 236 children across 4 RCCs. In some cases the administrative data also showed inconsistencies or missing information for specific questions/variables and in these cases data for a specific RCC was dropped from the analysis.

Table 4.1.2: Health and Disability Status of Children in RCCs (%)¹²

Health/Disability status	Cahul	Ciniseuti	Hirbovat	Nisporeni	Total Sample
No disability or health issue	-	78	-	15	34
Somatic disease	-	18	-	-	8
Have somatic disease, disability, and mental delay	-	2	-	-	1
Disability (physical, cognitive, or sensory)	98	2	100	8	46
Mental delay (learning difficulty)	2	-	-	78	11
Total (% rounded)	100	100	100	100	100

N= 236; Source: P4EC administrative data on children in RCCs.

Majority of children cared for by their biological family prior to admission to an RCC. Regarding form of care prior to institutionalization, in total across the RCCs, 90% of the children were cared for by their biological family, some were looked after by their extended family, a few were in placement centers (temporary centers where children are placed until a permanent solution is found) and a few in the Cahul, Ciniseuti, and Hirbovat RCCs were in the care of RCCs (Table 4.1.3). The Nisporeni RCC is the exception to this average with a lower percentage of children having been cared for by their biological family prior to institutionalization.

Table 4.1.3: Form of care prior to institutionalization disaggregated by child status and districts (%)

District	Biological family	Extended family	Placement Center	Residential institution
Cahul	98	-	-	2
Nisporeni	78	22	-	-
Ciniseuti	88	10	-	2
Hirbovat	92	4	1	3
Total	90	8	1	1

N=236; Source: P4EC administrative data on children in RCCs.

Deinstitutionalized children continue to face challenges in Moldova: The evaluation survey shows that deinstitutionalized children and their caregivers continue to face challenges in the country. Only 21% of respondents felt that deinstitutionalized children and their caregivers face “no challenges;” 66% felt they did face some sort of challenge. The majority of the respondents identified two challenges – 59% said “family risk factors,” and 54% said “lack of attachment between the family and child.” Additionally, 41% felt that children face stigma from the community. As seen in Table 4.1.4, community social workers and social work specialists use a variety of techniques to help deinstitutionalized children and their caregivers deal with these challenges: using a family care plan, referrals to other services, and a variety of counseling services. The lowest percentages relative to other techniques used are seen for disability rehabilitation (75%), and work with the community (76%).

¹² All of the figures are rounded to the nearest integers. For example, 7.3% is rounded to 7% while 7.8% is rounded to 8%.

Table 4.1.4: Challenges Faced and Addressed by Deinstitutionalized Children (%)

Challenges Faced by Deinstitutionalized Children	Yes	Refused*
What, if any, are some particular challenges facing deinstitutionalized children and their caregivers?		
No challenges	21	9
Stigma from the community	41	9
Lack of access to school	12	9
Family risk factors	59	10
Attachment between the family and child is lacking	54	9
Access to services	19	9
How are these challenges being addressed?		
With the social worker through the family care plan	89	7
Through referral to other services	84	7
Through a special education plan with the school	88	7
Counseling services for the child	87	8
Counseling services for the parents/caregiver	87	7
Counseling for the family	84	8
Disability rehabilitation or other services	75	9
Work with the community	76	7

Source: NORC evaluation survey

Note: *Respondents who refused to answer the question.

These survey findings are supported by the focus group respondents. When asked if children face any challenges when they leave RCCs to return to their families or join a new family, all focus groups that discussed the issue felt that there was at least some sort of adjustment period for children and their caregivers. As part of the adjustment, focus group respondents felt the child may find it difficult to get used to family life: he/she is receiving more individual attention from a caregiver and needs to be “punctual and obedient” or the opposite – he/she is living with a less regular schedule and rules for meals and activities; the child may need to reintegrate with siblings he/she hasn’t interacted with for many years; and he/she may have difficulty with attachment (11 focus groups with children, parents, community social workers, multidisciplinary teams, and mayors). For children reintegrating back into their families, focus group respondents felt these children may feel anger, hurt, and/or mistrust towards their parents for being placed in an RCC and wary of how they will be treated upon their return; they may isolate themselves (3 focus groups with children, community social workers, and multidisciplinary teams).

Focus group respondents clarified that the level of success of deinstitutionalization depends on the child’s experience at the RCC and treatment in the family in which the child is placed (2 focus groups with children and mayors); when a child has spent a long time in an RCC, he/she doesn’t have basic life skills such as how to plan their time every day and how to manage their finances (focus group with social work specialists) and if the child was placed in an RCC at birth, the staff and other children there are their only “family” so it is difficult for him/her to leave (focus group with parents).

Children with disabilities, those in poor families, and older children face more challenges after deinstitutionalization: The evaluation survey found that half of the social worker respondents felt that children who have been deinstitutionalized are “somewhat” adapting well and 38% felt they were “mostly” adapting well. Gender does not seem to be a factor in level of adaptation whereas socioeconomic status and age seem to play significant roles. Children with learning difficulties (66%); children with physical, cognitive, or sensory disabilities (65%); children from poor families (62%), and

older children (51%), are perceived as facing more challenges than the other groups, as seen in Table 4.1.5. The challenge of reintegration of children with cognitive disabilities was also mentioned in a focus group with community social workers from Ungheni and Falesti.

Table 4.1.5: Categories of Deinstitutionalized Children Facing more Challenges (%)

Q76: Are there any categories of deinstitutionalized children who face more challenges than others?	Yes	Refused*
Children with learning disabilities	66	11
Children with disabilities	65	12
Children from poor families	62	11
Older children	51	12
Boys	47	11
Girls	41	14
Children with chronic illnesses	41	12
Children who are of an ethnic minority	37	20
Younger children	30	12

*Respondents who refused to answer the question.

Source: NORC evaluation survey

Focus group respondents confirmed the finding that children from vulnerable families face more challenges after deinstitutionalization. They felt reintegration is more challenging if the child comes from a vulnerable family versus those from “good” families who are in RCCs because their parents had left the country to find work (7 focus groups with children, parents, community social workers, social work specialists, and mayors). They explained that vulnerable families more acutely feel the financial burden of an additional child to clothe, feed, and buy school supplies for (6 focus groups with children, parents, multidisciplinary teams, and mayors). Additionally, while some focus groups with children felt that some parents are very happy to have their children back and make an effort to correct the mistakes for which their child was taken away by providing spiritual warmth, paying more attention, and/or changing their personal lives (2 focus groups with children), they felt that other parents don’t want their children to return home (focus group with children), have “forgotten how to be responsible towards their children (focus groups with social work specialists), or are unable to understand their children (focus group with children).

“Parents were supported financially because they need this to create favorable circumstances for the child. They were engaged in an individualized plan, were engaged in activities. After a certain period of time, when we make our tracking we see that from a 100% of reintegration trial 2-3% are a total failure. The reintegration is more difficult in families where there is alcohol abuse. If the family was socially vulnerable, we tried very hard to integrate the parents into the labor market. Where there is substance abuse (alcohol) we can’t do much.” (Social work specialist from focus group with participants from Ungheni and Falesti)

For these families where family risk factors still persist, focus group respondents in the FGDs with community social workers, social work specialists, and multidisciplinary teams felt that parents need to be trained before their children are returned to them and questioned the utility of reintegrating children if the family has not changed. Such responses imply that there are some cases in which children are reintegrated back into families that continue to have the same problems for which the children had initially been separated.

“...but if the child has been removed from a social vulnerable family with an inappropriate behavior and was taken into an institution and the family in question didn’t returned to a normal livelihoods and the kid was

brought back in that family, what is the point?! I mean, you must find a normal environment for him and not bring him back in bad conditions.” (Female mayor from Soroca)

In Kils, RCC directors also expressed concern regarding the ability of caregivers to take care of children who are deinstitutionalized, sharing that they feel children are placed from vulnerable families and that returning them to the same families puts them at-risk for not having their needs adequately met. This perspective seems to assume that the families would not receive any supports or services to address their vulnerabilities. The lack of services at the community level (especially in rural areas), including lack of support groups and parenting skills training, was mentioned frequently as an issue for vulnerable families, both those at-risk and reunification cases.

“I worry that they [the children from institution to be reintegrated] will be rejected and that their families will not supervise their care and health situations” (RCC director)

“The community is not ready to receive these children. Society is not ready to accept them.” (RCC director)

"Our children were warm, eating four times a day, participating in activities. Parents are all worrying if they will have good conditions to raise their children. Support received for the first 6 months initially is good and well received but what will they do after the aid is gone?" (RCC director)

For children placed in alternative families, focus group respondents felt that a child can experience spiritual warmth – although it is not the same as from a biological mother – and be well taken care of although, even if treated well, a child may not be able to adjust to family that is not his/her own (focus group with children from ABC).

“I believe that children, after they had some suffering, they think they will never love again, they get disappointed about love thinking they will not be able to love anyone, they think that in the foster family he will not be loved the way he wants to be loved and he wants to close himself and stand there until they come [wait until someone reaches out to him]...” (girl from ABC in Calarasi)

A focus group with a multidisciplinary team from Cahul felt that the adjustment period for children placed in families in villages is longer than for those in cities due to greater time availability of caregivers in cities to provide individual attention to the child.

“You know I think for people who are in the villages it is a little harder to adjust to children who come from other families. Why? Because they are very busy with a lot of work around the house and then cannot give as much attention to that child as a city family offers. The family in the city can work 8 hours or 10 hours and after that all the time is in contact with the child and they have longer to discuss, see each other... compared to the man from the village that has more work to do and the period of accommodation can be longer ...” (male member of Cahul multidisciplinary team)

Some mayors had a negative stereotype of children coming out of RCCs, and felt that children from vulnerable families have no “family upbringing” and will have behavior problems, mistreating their foster parents (2 focus groups with mayors)

Follow-up social services to families of reintegrated children exist but can be improved: Both community social workers and social work specialists responded in the survey that they provide several follow-up services to families with reintegrated children. On average, 86% of respondents say they work with families of reintegrated children in the following ways: provide access to cash benefits and other material assistance, have regular home or office visits, or visits to the child’s school, represent the child at

gatekeeping meetings, arrange multidisciplinary meetings, provide referrals to other services, and provide parent and child counseling. The lowest responses were for housing services (41%); employment/household income support (67%); and parent education (68%), confirming the focus group findings above that vulnerable families struggle financially to take care of their reintegrated children and the view that more parental education is needed prior to reintegration.

Focus groups with parents of children who are or were institutionalized in Soroca and Nisporeni discussed in-kind or cash aid. While it was always a help to receive any aid at all, it did not seem to be enough to cover all the basic needs.

“Very hard [for the social aid to cover needs]. Me for the first time when my first husband passed away, I received 212 lei for 3 children, two were at school, 1-no. Also – [cost of] paying for book rental [is] one girl-200, other- 100, other -60. The allowance has not been increased. I receive 1000 lei, 300- social aid, 700-pension, anyway it’s hard, they want to eat, there’s need of detergents, rice, porridge. The main-detergents and food, it’s hard but there are 3 children.” (Mother of child who is in an RCC, Soroca)

They also spoke of the difficulties in acquiring the aid; you need to be persistent in going through all the necessary steps.

“F4: Yes, I have received...my child has had a degree of disability for three years. I have received for transport, medicine, but it took me some effort...”

Mod: You mean it wasn’t that easy to ...?

F4: Sure, go there... come here... and now this diagnosis of disability

F2: And this is why I don’t even want to go anywhere... so much fuss...

F2: You can get some social assistance but it takes a lot of time and effort.

F5: Right right!” (Nisporeni mothers of children who are in RCCs) ¹³

“You have to make a lot of different visits in a lot of different places. Even if you manage to open some doors, others are closing, some say that you have no right, some say that you do have. So for [example], I have a disabled daughter, they said [to] me that I have no right to receive money for her because my husband has a wage of 2,000 lei/month.” (Mother of child who is in an RCC, Soroca)

Over 80% of the social worker evaluation survey respondents “strongly/somewhat agree” that the needs of deinstitutionalized children are being met (Table 4.1.6 below). Thus there is a difference between the opinions of social workers from across the project raions as reported in the evaluation survey and those of parents of parents of children who are or were institutionalized in Soroca and Nisporeni as reported through focus groups.

¹³ Here and in other quotes that include more than one respondent, the acronyms represent each individual. For example, “F4”, “F2”, and “F5” each represent a different female focus group respondent.

Table 4.1.6: Deinstitutionalized Children’s Needs and Placements (%)

Q78: Do you agree or disagree with the following regarding deinstitutionalized children:	Strongly agree	Somewhat agree
Needs are being adequately met in their family placement	17	73
Needs are being adequately met in their school placement	33	56
Needs are being adequately met in the community	17	69
Needs are being adequately met by the services available	31	59
Are in protective family care that ensures their safety and wellbeing	37	50
Are placed in well-planned placements	39	45
Are placed with their permanency in mind	44	45
Are placed with adequate consideration to their best interests	58	33

Source: NORC evaluation survey

Conclusions:

There is a perceived increase in number of children needing alternative care: Social work specialists, some community social workers and some mayors who participated in focus groups felt that the number of children separated from their biological families is increasing. This is attributed by social work specialists to improved identification of cases of children without adequate parental care by local authorities. There now exists a system to identify children in alternative care so there is a more accurate “counting” of these children, which may also be adding to the perception that the numbers have grown. Another commonly held view for the increase among focus group respondents was continued lack of jobs that forces more parents to leave their children behind to seek employment outside the country. Additionally, the decrease in the number of children being placed in residential centers has caused an increased need for various forms of alternative care such as foster homes, guardianship, and family type children’s homes.

Most of the children in the RCCs being targeted for assistance by P4EC have some form of physical or mental disability; only in the Ciniseuti RCC are the majority of children without disability.

Challenges after deinstitutionalization: Children as well as their caregivers (biological and alternative) continue to face challenges after deinstitutionalization; deinstitutionalized children with disabilities, those in poor families, and older children face more challenges than other types of children. Both the focus groups and the evaluation survey highlighted family risk factors; lack of attachment between the family and child; lack of acceptance in the community; and inadequacy of follow-up services such as cash aid/resources and parental/caregiver education as being the main challenges faced by families with deinstitutionalized children. Additionally, the focus group discussions stressed more psycho-social factors such as a new environment with different routines, challenges with attachment, and lack of life skills as being the main challenges for deinstitutionalized children. Both the focus groups and evaluation survey highlighted that children from vulnerable families and older children face more challenges after deinstitutionalization than other groups.

Question 2: Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? Did the program impact beyond direct services?

Sub-questions:

- a) Did the project provide a core package of services to help ensure that residential care is prevented when possible and that reunified and deinstitutionalized children and at-risk children remain in family care?
- b) Are there fewer children living in residential care facilities?
- c) Is the wellbeing of deinstitutionalized children assessed as being adequate?
- d) Have there been other unanticipated positive or negative results of the program

Findings:

Alcoholic parents, lack of employment opportunities, and migration are key reasons for child separation: By far the most mentioned reason that children end up being separated from their families is alcoholic parents (22 focus groups with children, parents, gatekeeping commissions, mayors, multidisciplinary teams, social work specialists, community social workers). Other main reasons that lead to child separation are parents who migrate to other countries in search of jobs and leave their children behind (16 focus groups with children, mayors, multidisciplinary teams, social work specialists, and community social workers), poverty at a level where parents are not able to care for their children (15 focus groups with children, parents, multidisciplinary teams, and community social workers), divorce or single parents (14 focus groups with children, mayors, multidisciplinary teams, and community social workers), negligent parents (12 focus groups with children, multidisciplinary teams, social work specialists, and community social workers), domestic violence in the home (11 focus groups with children, parents, gatekeeping commissions, social work specialists, and community social workers), child abandonment (10 focus groups with children, mayors, multidisciplinary teams, social work specialists, and community social workers), and deceased parents (8 focus groups with children, gatekeeping commissions, and mayors).

F1: There are a lot of alcohol addicted people in villages... This is one of the most important motives.

F3: This is the first one.

F6: And it's followed by negligence.

F1: The mother comes home drunk; they all go to sleep, and who is taking care of the child?" (Singerei community social workers)

F1: The main cause is lack of jobs. People don't have a job, don't have conditions for life.

F4: They have no job, no place to work, not out of situation. No finance, no work place, that is most important.

MOD: So they have no job, here begins...

F1: ...alcoholism, begging, negligence...

F8: One of the causes is lower educational level, or primary, or middle unfinished. They have not even a profession." (Causeni community social workers)

Other reasons for separation due to parental behavior mentioned by a few focus groups were quarreling parents, criminal parents, parents with health issues, and uneducated parents (6 focus groups with children, community social workers, and multidisciplinary teams). We found through focus groups that children may be separated from their parents due to the child’s behavior or condition. Primarily child focus group respondents mentioned these reasons, which consisted of aggressive or “inappropriate behavior”, committing a crime or doing something wrong, and disability (5 focus groups with children and 1 focus group with social work specialists). Only in the case of committing a crime was this reason mentioned by a demographic other than children (focus group with social work specialists).

Guardianship or alternative family care are positively-viewed alternatives to staying with biological parents: A large majority of focus group participants who discussed the issue (not all FGDs discussed it) felt that while the best solution is for children to stay in their biological families, when this is not a possibility, it is best to try to find a good placement among relatives (16 different focus groups with children, parents, gatekeeping commissions, multidisciplinary teams, mayors, social work specialists, and community social workers) – grandparents in particular were mentioned as the best alternative by children and parents (9 focus groups with children and 3 with parents).

“F7: As it is said blood is thicker than water; sisters, brothers, grandparents and relatives are the closest people.

MOD: Why is it good to stay with your grandparents and not with other people?

*F4: Because grandparents will love us the same way they loved our parents as we are their next generation.”
(Children from the ABC in Calarasi)*

According to the evaluation survey, guardianship is the most prominent form of alternative care¹⁴ (97% of respondents), adoption as a placement option is largely available (67%), and foster care (APP) is somewhat available (47%) as seen in Table 4.2.1. Other types of alternative care were viewed as available by only a fraction of the respondents. For the alternative care types that were available, respondents were asked to rate the quality of service for each type of alternative care as seen in Table 4.2.1. On average over 87% said that the alternative care is “excellent/good quality,” boarding schools were below this average with 77% viewing them as “excellent/good” quality.

Table 4.2.1: Availability and Quality of Alternative Care in the Raion/Community (%)

Q26: What types of alternative care are in place in your raion/community to meet the needs of children without adequate parental care?	Yes	Excellent Quality	Good Quality	Fair Quality	Poor Quality
Guardianship	97	31	58	10	1
APP	47	32	58	10	0
CCTF	28	24	67	6	1
Community group home	18	28	58	9	0
Adoption	67	42	51	5	1
Emergency/temporary placement center	26	29	57	10	1
Boarding schools	7	27	50	14	5
Other resident institution (not boarding school)	9	31	50	4	4

Source: NORC evaluation survey

¹⁴ In Moldova, the term placement is used for non-permanent solutions only and adoption is considered a form of alternative care. Therefore, we use the Moldovan terminology in this report.

Of the alternatives that did not involve relatives, focus group respondents believed foster care/APP (8 focus groups with multidisciplinary teams, gatekeeping commissions, mayors, social work specialists, and community social workers), family-type homes (CCTF); 7 focus groups with children, gatekeeping commissions, multidisciplinary teams, mayors, social work specialists, and community social workers), and adoption as a placement option; 4 focus groups with children, gatekeeping commissions, and social work specialists) are positive placements. One focus group with girls 12-14 mentioned neighbors as a good alternative. Temporary placement centers were also viewed by some as a positive option for families to temporarily place their children while dealing with an issue and then the children can return home (2 focus groups with gatekeeping commissions and mayors).

“The best and the fairest is the family-type home [CCTF], where the child can grow and be educated in the family, because to be educated in the family it means here he is taught to create a budget, he sees his parents, even they are not his biological parents, the dad is working, the mother does something else, they are a model for him and when he turns 18, when he goes into the street he is not as if he was from the orphanage. I would say there [in the RCC] they are also educated, but here he gets an education for life, if he behaves well the family adopts him or supports him to further his education.” (Nisporeni mayor)

“In a family-type home [CCTF], there are fewer children than in an RCC so there is more personalized care and more love and attention, they are integrated in the society - going to school with everyone else and not isolated at a boarding school.” (Cahul multidisciplinary team member)

While almost all focus group respondents believed family-based care was far preferred to institutional care, respondents from three out of the six focus groups with parents felt that RCCs could be a positive option and there was a debate with differences in opinion in a fourth group.

“To tell you honestly, my kids learned at the boarding school from Ungheni. All 3 kids were there and learned there while I was in the hospital, I couldn't sit beside them. With my husband - we broke up a long time ago ... I'm very pleased and thankful now. He [my son] entered the university and received a scholarship at the Chisinau- Ecology faculty and has finished all 4 years of study. After studies of the ecology, he went at another university and studied there for 2 more years. The same thing happened and with my second son everything was normal, and everything was good.” (Mother from Ungheni)

RCCs and living with strangers are negatively-viewed alternatives to family care: In focus groups with children, RCCs were the most likely to be mentioned as a negative placement option. They felt that RCCs did not provide the love and care that a family provides.

“You have no one to open your secrets, to talk to. We are not treated as in the family.” (Girl aged 15 -17 in Orhei)

Otherwise, a variety of negatively-viewed placements that did not involve relatives, such as with neighbors, foster homes, adopted families, and placement centers, were mentioned by a few focus groups. The common reason the placements were viewed negatively among focus group respondents was cases of children who were taken in primarily to receive financial compensation or those where the children were made to work or feel like they owed the family something for taking them in.

“There are people who take these children only for money. They want to get money for them and stay home. And they don't provide these children with any education. They just want to have this salary... It is a kind of business. I had a case when the child got a bad burn, there is investigation now and the child is still there and the child says 'I got this burn because I made a spot on my blouse'. You might think that this is fiction but these are the things which ...” (Ungheni and Falesti mayors)

Non-family members are usually considered as not providing support to children: In the FGDs with children, participants were asked to create a flower using the petals to indicate which types of people helped children the most and then they were asked which types of people helped children the least. From this activity, children listed several types of people who were least likely to offer children support:

- Other children such as friends “because they constantly criticize you, they don’t know how to help, or are not interested in helping”, indifferent classmates, and cousins who don’t have time (3 FGDs)
- Neighbors, RCCs (2 FGDs)
- Grandparents, adoptive parents, strangers, hospitals, prisons (1 FGD)

Children listed a number of reasons for the lack of support: they envy us, they are indifferent, some people are distant, they do not trust the children, they don’t need us, they don’t understand, are critical, not supportive, and much more interested in their own problems because they care only about themselves.

Personal relationships and government structures considered as providing support to children: In the petals of the flowers drawn by children in focus groups, they mentioned people in their lives that support them. Other than parents, those mentioned were:

- Grandparents, relatives in general, teachers or the school (9 FGDs)
- Siblings (8 FGDs)
- Social workers (6 FGDs)
- Friends (5 FGDs)
- Psychologists, neighbors (4 FGDs)
- Police, doctors (2 FGDs)
- Cousins, other children, journalists, strangers, acquaintances on the internet, the state, boarding school, hospital, and telephone hotline (1 FGD)

State and parents are considered as being responsible for the care and protection of children: When asked in focus groups who is responsible for the care and protection of children in Moldova, the main response was the state (7 focus groups with children, parents, mayors, multidisciplinary teams, and community social workers) and parents (7 focus groups with children, parents, mayors, social work specialists, and community social workers). Mayors were mentioned by three focus groups (with mayors and parents), and others mentioned in a single focus group were guardians (by mayors), neighbors (by children), and family friends (by children).

There are significant differences in wellbeing indicators across and within RCCs¹⁵: A variety of factors were considered in defining and measuring child wellbeing (see Annex II). Four categories with multiple indicators under each were identified which included health, safety, education, material, and psychosocial wellbeing. Data on current material wellbeing of children in RCCs was not collected by P4EC and is therefore not reported. As per Table 4.2.2, 6.

¹⁵ All data on child wellbeing is based on administrative data collected by raion social workers, supervised by P4EC.

Table 4.2.2: Wellbeing of Children across different RCCs

RCC location	Health	Safety	Education	Psycho-social
Cahul	-100% have disabilities -100% <i>sometimes</i> receive regular medical checkups	-100% feel safe in RCC and 52% feel safe in community -7% in regular contact with parents	-100% always supported with homework, school, and extracurricular activities	-64% confident -All show some negative emotions – 46% upset/concerned, rest aggressive and anxious
Ciniseuti	-78% without disability -47% <i>never</i> receive regular medical checkups	-100% Feel safe in RCC and community -62% in regular contact with parent(s)	-41% are never supported with homework, school, and extracurricular activities	-75% need stimulation and encouragement -64% do not display negative emotions
Hirbovat	-100% have disabilities -100% <i>always</i> receive medical checkups	-99% feel safe in community always/most of the time -All in regular contact with parents	-100% always supported with homework, school, and extracurricular activities	-59% need stimulation and encouragement -75% show aggressiveness and 15% are upset/concerned
Nisporeni	-77% have mental delay -66.67% <i>sometimes</i> receive regular medical check ups	-81% in regular contact with parents	-74% always supported with homework, school, and extracurricular activities	-68% need stimulation and encouragement

Source: P4EC administrative data on children in RCCs.

Medical attention: As seen in Table 4.1.2 in Evaluation Question 1, the largest percent of children without disabilities among those in RCCs are seen Ciniseuti and Nisporeni. In Ciniseuti 78% of all children are without disabilities and in Nisporeni 15% of all children are without disabilities. As seen in Table 4.2.3 all the children in RCCs in Cahul, Hirbovat and Nisporeni are registered with a family doctor and in Ciniseuti 53 of 60 are registered. This implies having health records, medical checks, and getting vaccinated. Despite this, only 35% of the children with health issues, including disability, were able to always make regular checks and receive necessary treatment.

Table 4.2.3: Number of children that are registered with a family doctor

District	# Registered Children	# Non-registered Children	Total
Cahul	58		58
Ciniseuti	53	7	60
Hirbovat	73		73
Nisporeni	39		39
Total	223	7	230

Source: P4EC administrative data on children in RCCs

In Hirbovat, all children always received medical checkups and necessary treatment while 47% of the children in Ciniseuti never received regular medical checkups or necessary treatment (note that 78% of the children in this RCC are without health or disability issues). Additionally, in Nisporeni where 67% of the children have learning difficulties, the children only sometimes received medical checkups and/or necessary treatment (see Table 4.2.4).

Table 4.2.4: Children received regular medical checkups and necessary treatment (%)

District	Always	Most of the time	Sometimes	Never
Cahul	-	-	100	-
Ciniseuti	4	10	39	47
Hirbovat	100	-	-	-
Nisporenti	14	14	67	6
Total	35	5	46	13

Source: P4EC administrative data on children in RCCs

Safety: As seen in Table 4.2.5 all the children in 3 of the 4 RCCs always feel loved and safe (Cahul, Ciniseuti, and Hirbovat), but only 1 RCC reported all children feeling safe in the community (Ciniseuti). Safety issues appear to be of more concern in Cahul where 49% of the children report only sometimes feeling safe in the community. It is, however, unclear as to who collected this information from children. If the assessors were RCC staff, the children might or might not express their true perception.

Table 4.2.5: Feeling of Safety in the RCC and Community (%)

Percent of Children that:	Cahul	Ciniseuti	Hirbovat	Niporeni	Total
Feel safe and loved in the RCC (is not exposed to violence, the staff applying non-violent forms of managing challenging behavior of the child, etc.)					
Always	100	100	100	54	93
Most of the time	-	-	-	46	7
Feel safe in the community (able to move freely around the community)					
Always	52	100	25	-	57
Most of the time	-	-	74	-	28
Sometimes	49	-	-	-	15
Never	-	-	1	-	1

Source: P4EC administrative data on children in RCCs. There was no data filled in for Nisporeni for this question since it is an auxiliary school.

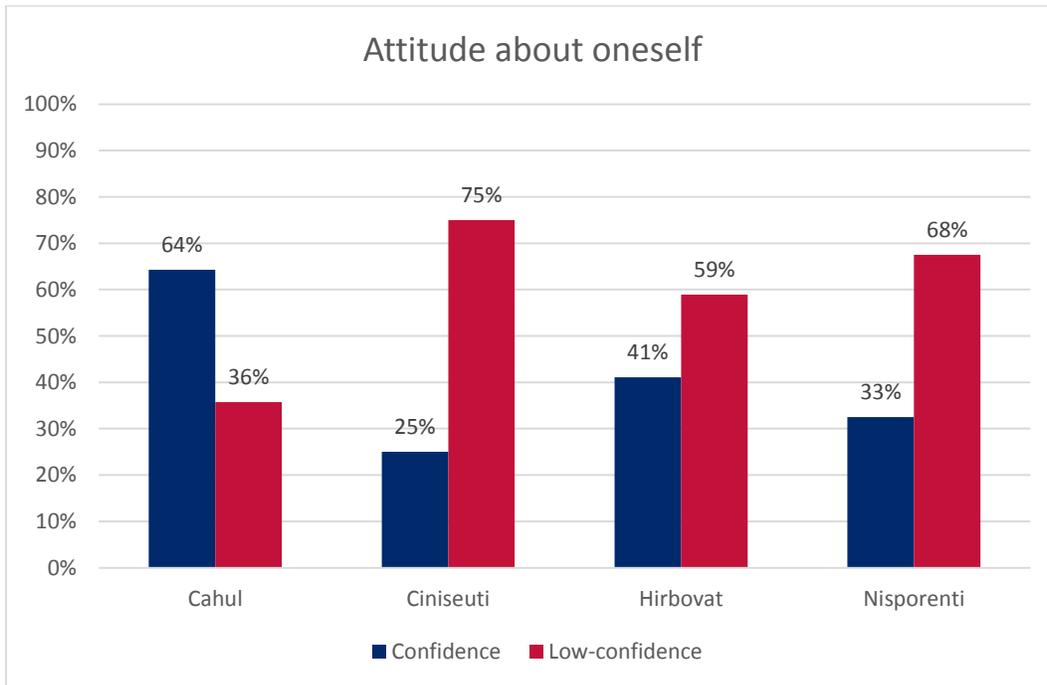
As seen in Table 4.2.6 despite being in an RCC most children are in contact with their family and at most only 0% of children in each RCC have no communication with their family. The most common form of contact is children visiting the family and/or some combination of both parent and child visits as well as phone calls.

Table 4.2.6: Contact with the Family (count)

Row Labels	Cahul	Ciniseuti	Hirbovat	Nisporenti	Grand Total
Parent visiting the institution, children visiting the family		1	23		24
Parent visiting the institution, children visiting the family, phone calls		6	34		40
Parent visiting the institution, children visiting the family, internet correspondence			6		6
Parent visiting the institution, phone calls	7	1			8
Children visiting the family	5	27	3	34	69
Children visiting the family, phone calls		17			17
Phone calls	28	2		3	33
No communication	6	6	5	1	18
Parent visiting the institution				4	4
Parent visiting the institution, children visiting the family, phone calls, internet correspondence			2		2
Phone calls, internet correspondence	12				12
Grand Total	58	60	73	42	233

Psycho-social Wellbeing: The majority of the children across 3 RCCs were assessed as having low confidence -- Ciniseuti (74%), Hirbovat (59%) and Nisporenti (68%), and on average only 33% were assessed as being confident. In Cahul, however, about 64% of the children in the RCC were assessed as being confident, and about 36% were assessed as having low confidence.

Graph 4.2.1: Attitude about oneself



Source: P4EC administrative data on children in RCCs

Table 4.2.7 shows that that an overwhelming proportion of children displayed some form of negative emotion across all RCCs with 43% of them expressing “aggressiveness”, followed by 21% being “upset and/or concerned”, and 16% of the children showing “anxiety”. Within specific RCCs, Hirbovat has a much larger percentage of children displaying aggressiveness (75%) than the other RCCs and Ciniseuti has by far the largest percent of children who do not display negative emotions.

Table 4.2.7: Children display negative emotions¹⁶(%)

District	Aggressiveness	Anxiety	Upset/Concern	Does not display
Cahul	26	28	46	-
Ciniseuti	13	22	-	65
Hirbovat	75	3	15	7
Total	43	16	21	20

Source: P4EC administrative data on children in RCCs

Education: As shown in table 4.2.8, in 3 of the 4 RCCs 74% to 100% of the children receive some kind of support with schooling, homework, and school extracurricular activities. However, the frequency of such help differs largely among the four RCCs. The exception is Ciniseuti where 24% and 41% “seldom” or “never” get support.

Table 4.2.8: Support with school, homework, and school extracurricular activities (%)

District	Always	Often (1-2 times/week)	Seldom (1-2 times/month)	Never
Cahul	100	-	-	-
Ciniseuti	27	8	24	41
Hirbovat	100	-	-	-
Nisporeni	74	26	-	-
Total	77	6	6	11

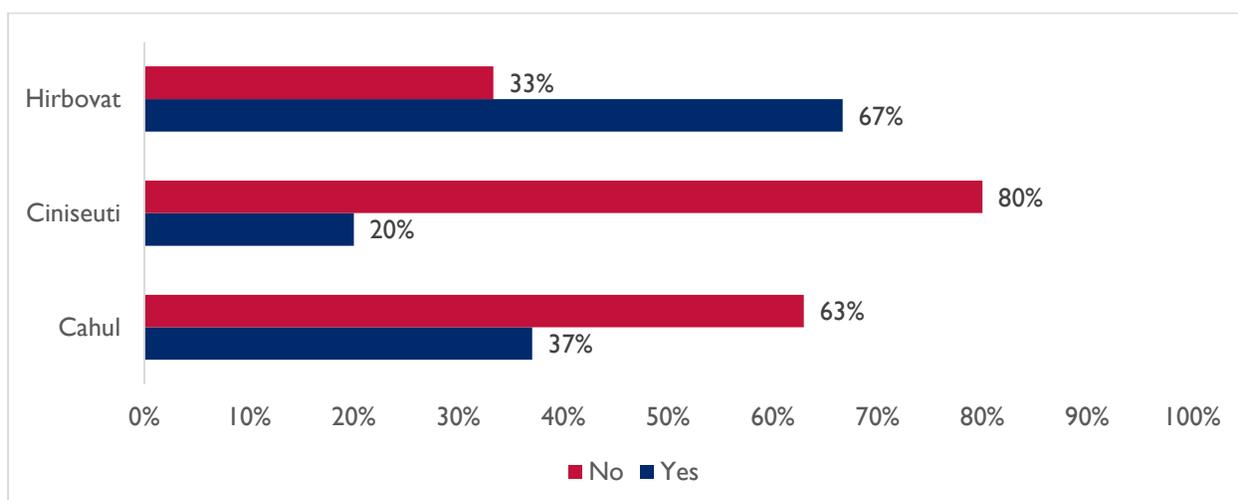
Source: P4EC administrative data on children in RCCs

Graph 4.2.2, shows the percentage of children with disabilities that are supported to achieve his/her potential in accordance with an individual educational plan. While the data for Cahul and Hirbovat show that all of the children received school support, 63% and 33% of the children with special needs in these two RCCs respectively didn’t receive any support to achieve their potential¹⁷. Ciniseuti, an RCC for neurological disabilities also shows 80% of the children not being supported to achieve their potential with an individual education plan.

¹⁶ The information for Cahul, Ciniseuti, and Hirbovat is about the type of negative emotions the child possess, while the information for Nisporeni is about the frequency of those negative emotions. Since the data for Nisporeni provided answer options inconsistent from the other raions, Nisporeni is excluded from this analysis.

¹⁷ Children in Cahul and Hirbovat, institutions for deaf children, are already receiving an education plan tailored to their sensory disability therefore those with only a sensory disability would not need an individual education plan.

Graph 4.2.2: Child with Disability is Supported with an Individual Education Plan



Note: There was no data for Nisporeni under this indicator.

Source: P4EC administrative data on children in RCCs

The results for children’s educational progress (Table 4.2.9 below) is consistent with the support they received (Table 4.2.7 above). A large proportion of children in Cahul, Hirbovat, and Nisporeni had good grades or had low grades but were making efforts to improve their grades. However, 20% of the children in Ciniseuti, where 41% of the children never received any school support, made no progress at school at all.

Table 4.2.9: The children made progress according to his/her potential¹⁸ (%)

District	Has good grades	Has low grades but striving	No progress
Cahul	49	49	2
Ciniseuti	42	38	20
Hirbovat	14	76	10
Nisporeni	59	39	3
Grand Total	39	52	9

Source: P4EC administrative data on children in RCCs

Chi-Square tests of independence: We conducted multiple tests of correlation to explore the relationships between children’s reported adaptability and the challenges they face. The tests were run on NORCs evaluation survey, so they are based on social workers perceptions on children’s adaptability and the challenges they face. We employed a series of chi-squared test, in which the null hypothesis is that answers to two separate questions (X and Y) are independent of each other. In the family of the chi-squared test, we selected the Person’s chi squared, also called the chi-square test for independence. This test compares the conditional distributions and rejects the null when these are different between each other (i.e. the variables are dependent or correlated). Then, if the confidence level alpha (α) is less than the p-value, we accept the null hypothesis of independence. If the opposite is true, we reject the

¹⁸ There are 10 children in Hirbovat reported as both “having good grades, and having low grades but striving.” Since these cases are inconsistent, they are excluded from the analysis.

null hypothesis, and the variables are considered dependent or correlated. The correlation tables for all tested questions are in Annex VII.

First, we are interested in the association between deinstitutionalized children's adaptability in the community with the challenges they faced. To measure children's adaptability, we used the survey question: "In general, are the children who have been deinstitutionalized in your raion/community adapting well?" The three response options are: "mostly", "somewhat", and "not at all". To capture the challenges the deinstitutionalized children faced, we used the survey question: "What, if any, are some particular challenges facing deinstitutionalized children and their caregivers?" The response options are: "no challenges", "stigma from the community", "lack of access to school", "family risk factors", "attachment between the family and child is lacking", "access to services", and "others". Respondents can choose multiple responses for this particular question. Based on the Chi-square test results, we observe a strong correlation between children's adaptability and the listed challenges -- stigma from community, lack of access to school, family risk factors, lack of attachment between the children and their families, and access to services. It's worth noting that the chi-square test only shows the existence of a correlation between the children's adaptability and the challenges they face, not the strength of the correlation.

Second, we checked if certain categories of deinstitutionalized children (*girls, boys, children with disabilities, children with learning disabilities, children with chronic illnesses, younger children, older children, ethnic minorities, and children from poor families*) are more likely to face particular challenges (*stigma from the community, lack of access to school, family risk factors such as substance abuse, mental health, low income, lack of attachment between the family and child, and access to services*). We found that most of the deinstitutionalized children groups have a strong correlation with the lack of attachment between the family and the child. We also observe a correlation between lack of access to schools and several subgroups of deinstitutionalized children, including *children with disabilities, children with learning disabilities, younger children, older children, ethnic minority, and children from poor families*. While both gender groups are correlated with lack of access to services, only girls and the children with disabilities group is statistically significantly correlated with stigma from the community.

Conclusions:

Alcoholic parents, lack of employment opportunities, and migration are the key reasons for child separation. Poverty, lack of jobs, alcoholism, and migration to find jobs all interact with each other to create the main sources of separation of children from their parents.

Guardianship best alternative to staying with biological parents: According to all stakeholders it is best for children to stay with biological parents and in the absence of this possibility, to stay with other relatives. RCCs are viewed as a negative placement by most children, with other negative placements being neighbors, foster homes, adopted families and placement centers.

The wellbeing of institutionalized children varies by institution and across indicators: Current wellbeing of children in RCC varies based on the data from 4 project RCCs targeted for assistance and deinstitutionalization. The data show that children in the Ciniceuti RCC, of which 78% do not have disabilities, have higher wellbeing indicators followed by children in Hirbovat. Children in the Cahul RCC show the lowest wellbeing indicators; it is difficult to state anything definitely regarding the Nisporeni RCC since they have a couple of missing wellbeing indicators.

Project-promoted family-based alternative care options of adoption and foster care can be expanded. While guardianship is widely available in communities, foster care is largely lacking and adoption, while available in most communities, can be made more widely available.

Question 3: Have prevention methods employed by the projects reduced risks of child/family separation?

Sub-questions:

- a) Are households with children at risk of family separation stabilized and strengthened?
- b) Were the relevant families chosen for inclusion in the project?
- c) Are children at risk of losing family care continuing to live in appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capabilities and service delivery?

Findings:

Vulnerable families need to be able to secure jobs in Moldova. According to focus group respondents, the lack of jobs in Moldova is a key issue for vulnerable families (5 focus groups with parents, community social workers, and multidisciplinary teams). Key informant respondents reported that children with parents who have migrated to find work are an especially vulnerable group and focus group respondents felt there is a need to find a solution to increasing the employment rate and/or helping parents find a job (3 focus groups with mayors and community social workers).

“To give a job to those, who are able to work, so that parents could work and support their family, this is in the first place – no matter how low the wage is.” (Cahul parent)

Vulnerable families have difficulty in obtaining sufficient financial assistance. While poverty and lack of money to provide the necessary conditions to care for children is a common issue among vulnerable families, all of the focus groups with parents mentioned how challenging it is to actually receive social assistance. Focus group respondents mentioned how the application process can take a very long time and can be difficult to navigate and the amount of assistance is variable – some gave up on asking for it. They felt that medicines and healthcare for children is expensive and many parents do not receive any discount on medicines (4 focus groups with parents). There was particular mention by three focus groups (2 with parents and 1 with community social workers) of how small the allowance is for families with disabled children. According to a community social worker focus group respondent, the allowance is not nearly high enough to allow a parent to stay at home to care for the disabled child. Solutions proposed to this problem by focus group respondents were to provide an allowance large enough to enable a parent to stay home and provide full-time care or support a professional care taker, enabling the parent to work (focus group with community social workers in Singerei). An increase in assistance was also mentioned as a solution to prevent parents from leaving their children to go find work outside the country (focus group with multidisciplinary committee members in Singerei).

On the other hand, some focus group respondents felt that the problem was too much dependence on social assistance. They believed it can create a dependency where the family does not try to find other solutions and merely waits for the next “free” paycheck (the same focus group with community social workers in Singerei where increasing the allowance amount was mentioned). One focus group with gatekeeping commission members from Orhei, Calarasi, and Nisporeni felt that families should not receive aid without something in return – for example they should be required to provide community service work and those families that do receive social assistance should be closely monitored to make sure it is being used as intended.

“That's like in medicine: first the disease has to be prevented to avoid treating it later. We do not have the school for parents. Parents should be responsible, and taught, they must know how to manage the money, and if don't have a job the resolution of the situation does not come from sleeping, eating, drinking and

carelessness. You have to find another way out, or work occasionally - daily or seasonally, but there is still a way out. They learned that they are given social support or family support and they do not need anything nor do they care. The family's okay as long as there is money, as money runs out; they are the first at the door to ask for help.” (District social worker from Falesti or Ungheni)

The above findings were confirmed by the evaluation survey. Respondents were asked which risk factors make a family more vulnerable, and to select all that apply. All of the risk factors listed were confirmed as making families more vulnerable.¹⁹ There was also consensus across all the protective factors making a family more able to protect and care for their child: meeting family needs with resources available; good family relationships; bonding and attachment between child/children and family; emotional resiliency; knowledge of child development; knowledge of child health and education; access to basic services; connection to community; and connection to extended family.

Prevention services are needed: parental skills education, family planning, and early intervention.

According to the focus group respondents, important factors to preventing the separation of children from their families are early intervention (for example when the child is young or at the start of the problem) (focus group with Singerei community social workers) and prevention services such as emergency services, services for mother-child, and more diverse services such as other kinds of foster care (APP) (key informant interviews) in addition to education and support of parents or future parents.

“We focus on prevention. And the reason is rationalized in expenditures - the earlier we intervene in kindergarten, in school, than we will have much less spending in the future. That future strategies and policies will all focus more on the aspect of prevention of child abandonment, preventing child separation from the family.” (Head of Social Assistance and Family Protection Department, Ungheni)

“Abandonment prevention is very important and in order to keep children from institutions we need to have more services for prevention, for example day services, day care centers, etc.” (Ministry of Health)

Among focus group respondents, there was agreement across child care and protection providers that needed prevention services were parental skills training to educate parents on how to care for their children (7 focus groups with social work specialists, community social workers, gatekeeping commissions, and mayors) and educating families about contraception and family planning to avoid unwanted pregnancies (4 focus groups with community social workers, gatekeeping commissions, and mayors). Other prevention services that were felt to be important were: having psychologists available to support parents (4 focus groups with children and parents); building parent capacity to better understand their responsibilities (2 focus groups with community social workers and key informant interviews); and greater interaction with community social workers (2 focus groups with community social workers).

“Certain courses, training on how to start a family, how to take care of a child, what a child's needs are, what to do in case of ... etc. These courses would be very useful to young families or for the people who think about to make a family, but doesn't really have any idea how to do this, what is required from their part - to be good fathers, good spouses. These trainings should be introduced into school curricula or University.” (Gatekeeping commission member from Orhei, Calarasi, or Nisporeni)

¹⁹ This includes the following risk factors: limited or lack of family income, lack of adequate housing, unemployment/under employment, substance use/abuse, conflict with the law, domestic violence history, mental health, physical or other disabilities, isolation from the community/stigmatization by other community members, lack of access to services, relationship within the family, lack of attachments.

Substance use/abuse services and juvenile delinquency prevention programs needed in raions and more daycare services needed in communities. According to evaluation survey respondents, the most commonly available services to support vulnerable families are social assistance, case management, housing assistance services, public schooling, and kindergartens as demonstrated in Table 4.3.1. Services that are the least available are substance use/abuse services, job skills training programs for adults, and juvenile delinquency prevention programs.

In Moldova, specialized services are placed at the raion level and primary social services are placed at the community level. In the survey, social work specialists and community social workers answered the set of questions about services at their level of operation. That is, social work specialists answered questions about the raion (a yes would be provided if the service was at all available in the raion – either at the raion or community-level) and community social workers answered questions about their community (a yes would be provided if the service was available in the community²⁰). Primary social services that are equally available in communities across the raions are: social assistance, case management services for at-risk families, public schooling for children, and kindergartens. On the other hand, services that are considered to be less available across communities in a raion include: nongovernment financial assistance, daycare, and crèche services.

When asked if there are services strongly needed but not available, at the raion level 75% answered “yes” and at the community level 72% answered “yes.” The last two columns of Table 4.3.1 show the details of the services that were felt to be needed but not available. At both the raion and community level, substance use/abuse services and juvenile delinquency prevention programs are the most needed (mentioned by about 45% of respondents). Of note is that over half the community social workers felt that daycare services and special services for children with disabilities are needed.

²⁰ Based on the data that show the service is available at the community-level when it is known that the service is only placed at the raion-level, we can deduce that some respondents must have answered “yes” if the service is was available at the raion-level, as it is supposed to be per the system in Moldova.

Table 4.3.1: Availability and Need of Services to Support Vulnerable Families (%)

Services to support vulnerable families	In Raion		In Community	
	Available	Strongly needed but not available	Available	Strongly needed but not available
Financial assistance – government cash assistance / other social assistance program	100	19	99	15
Financial assistance – nongovernment	78	19	33	45
Case management for families at-risk	100	15	95	22
Parenting support services	89	30	43	38
Other family support	36	37	16	17
Mental health counseling	61	30	40	45
Substance use/abuse services	33	48	37	43
Housing assistance services	94	15	92	18
Employment / income generation services	78	19	33	38
Public schooling for children	89	15	91	16
Job skills training programs for adults	47	22	12	41
Continuing education for adults	39	30	13	41
Daycare services	94	26	25	60
Kindergartens	92	15	92	14
Creche	64	26	32	24
Respite care for children with disabilities	81	30	34	45
Special services for children with disabilities	86	30	31	51
Juvenile delinquency prevention programs	44	48	30	45
N	36	27	264	191

Source: NORC evaluation survey

KIIs with social workers showed that services they perceived as important to reintegration and/or prevention with vulnerable families were material/social assistance, case management, visits by social workers (monitoring), respite services, and shelters. They also felt the services that were needed to further assist these families were: before and after school programs, day care, and parenting groups.

The importance of childcare services was confirmed through focus groups with parents and evident through the survey as mentioned above. Parents in Soroca pointed out how it is not enough to increase the number of jobs, they need childcare that would allow them to take a job.

“It’s not that there is not a job, it means there is not a permanent job. Me for example I’m a single mother, the elder daughter is 10, the youngest one is 3, so I can’t go to work because in the village we don’t have a kindergarten, plus to that I have a deaf and dumb mother and a 80 years old grandmother who is blind.”
(Soroca parent)

“Wherever you go to find a job, they say that if you have a disabled person at home, then you will not be able to work; the second or the third day, you are dismissed because you get some calls from home where there

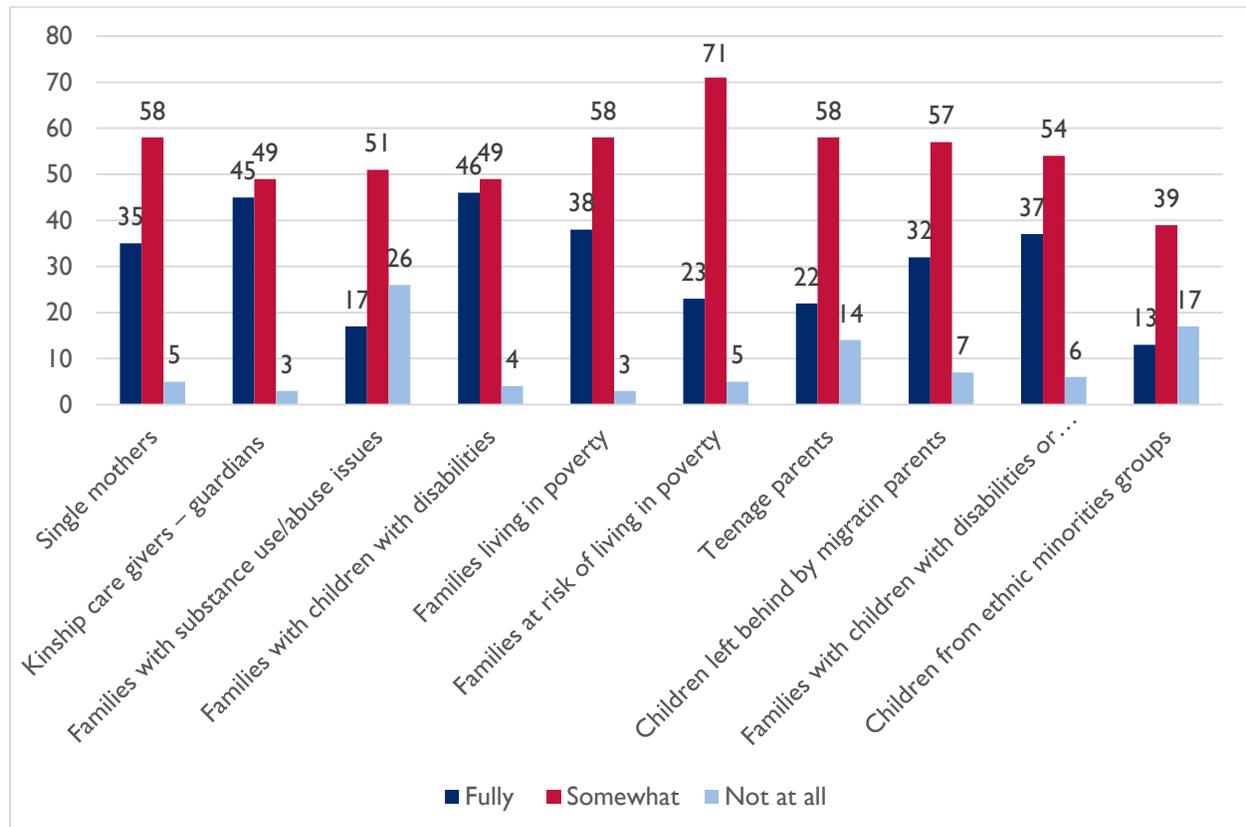
are some problems and they say you must work at work. They tell you to go home as they do not need you anymore and indeed, you are still with your own problems (Singerei parent)”

As reported through key informant interviews, raions in which P4EC worked previously have more complex services and are looking to the development of new service types for more complex situations; districts in which P4EC are working for the first time are looking at the further development of core services like foster care (APP) and family support.

Childcare and protection services are somewhat adequate to meet the needs of families. Respondents to the evaluation survey were asked “How adequate do you believe the services generally are to meet the needs of families to help ensure that children can stay in or be returned to family care?” At the raion level about a third of the social work specialists responded “fully adequate” while about two-thirds responded “somewhat adequate.” A similar response was given by the community social workers regarding the adequacy of services at the community level.

The evaluation survey also asked respondents to rate the adequacy of existing services to meet the needs of special populations of families in their raion/community. Graph 4.3.1 below shows that none of the existing services were considered to be “fully” adequate by a majority of the respondents. However, a majority of the respondents considered the existing services to be “somewhat/fully” adequate for special populations of families. Of all services, the top three that were considered to be “not at all” adequate include services for: (1) families with substance use/abuse issues (26%), (2) children from ethnic minority groups (7%), and (3) teenage parents (14%).

Graph 4.3.1: Adequacy of Existing Services for Special Populations of Families

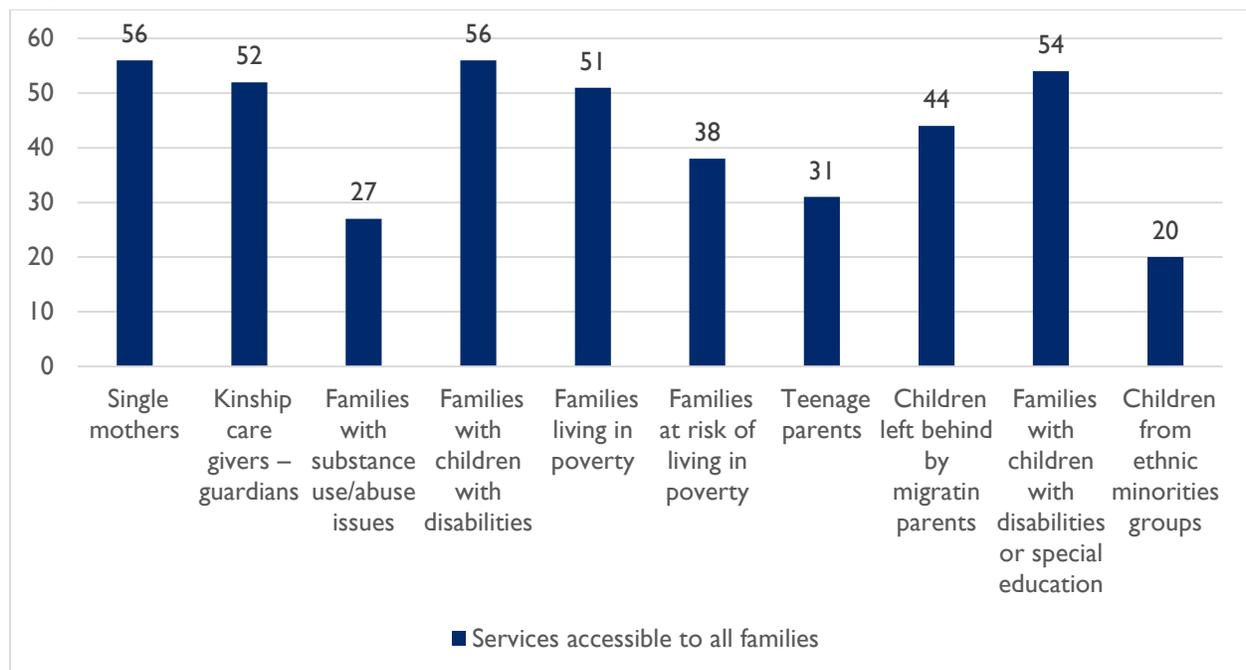


Source: NORC evaluation survey

Most families are able to access services. When asked “Are families in need generally able to access the services in your raion/community provided to help ensure that children can stay in or be returned to family care?” a large majority felt that services were accessible to most families; 29% of respondents to the evaluation survey said “yes, all families”; 51% said “yes, most families”; and 20% said “yes, some families.” Of those indicating that only some families in need are generally able to access services, 62% said that mental health counseling and daycare services are generally not accessible in the raion/community, and 56% said that special services for children with disabilities are generally not accessible. The top two reasons given for services not being accessible are: (1) the service does not exist in the families’ community (69%); and (2) due to physical disability the family cannot get to the service (66%).

Respondents were also asked to rate the level of access to services by special populations of families, as those being accessible to all families, most families, some families and not accessible to any families. Graph 4.3.2 below shows that according to respondents’ perception of those services that are “accessible to all families,” children from ethnic minority groups, families with substance use/abuse issues, and teenage parents face more challenges compared to other family groups.

Graph 4.3.2: Services accessible to all families



Source: NORC evaluation survey

Support to children is available and effective. On average over 92% of survey respondents said that their department provides counseling directly to children and material support (such as school supplies); and on average 86% said that they provide referral to services to address physical/mobility disabilities, access to health services, special education support and child care. However, support services for disabilities and early childhood are somewhat lower with 72% stating they provide services to address cognitive/learning disabilities, 68% for referrals to early childhood support, 61% for mental health issues, and 52% to address visual/auditory disabilities. When asked about the effectiveness of this support, 63% of respondents felt it was “effective” and 37% felt it was “somewhat effective.”

Support to the whole family unit is available and somewhat effective: Respondents to the evaluation survey said that their department provides the following family support services to caregivers: access to

cash benefits or other financial assistance (100%); family case management (97%), counselling, disability services for children (90%), and referral to services (94%), specialist health care (92%), and child care (89%). A slightly smaller percent of respondents stated that their department provides the following support services to caregivers: 76% for social/psychosocial services for people with mental health issues; 75% for parenting education; and 67% for referral to alcohol or substance abuse treatment.

When asked “to what extent do you believe the support provided to caregivers by service providers improves their caregiving?” 45% responded “greatly improves” and 55% responded “somewhat improves.” Additionally 28% felt that as a result of access to family support services, the families’ ability to care for their children is “improving considerably;” 67% felt it is “improving some,” and 2% felt it is “staying the same.”

At the same time respondents identified the top three family support services that are most effective in improving a families’ ability to care for their children; those that need improvement in terms of availability, quality, effectiveness; and those that generally need to be improved. Table 4.3.3 shows only the highest three data points for each column. Support services that are considered the most effective in improving a families’ ability to care for their children include cash benefits or other financial assistance (64%), family case management (43%), and referral to services (16%). Looking at these three services, there were cases where they also were ranked among the highest three data points for additional improvement. For cash benefits or other financial assistance over one quarter of respondents feel it needs some form of improvement in availability (26.33%) and quality (26.33%) and over one third in effectiveness (38.33%); 13% of respondents felt that family case management services needs improvement in terms of quality. Two other services that were among the highest three that needed improvement include disability services for children, and alcohol and substance abuse treatment. There was strong consensus among respondents regarding which support services to families in general could be improved with the highest three being alcohol and substance abuse treatment (83%), disability services for children (82%), social/psychological services for people with mental health issues (76%), and specialist health care (76%)

Table 4.3.2: Effectiveness of support services to families

Support services to families	In your opinion what are the top three support services to families that: (% responding yes)				
	Are most effective in improving a families’ ability to care for their children (Q35)	Need improvement in terms of availability (Q37)	Need improvement in terms of quality (Q38)	Need improvement in terms of effectiveness (Q39)	Can be improved
Cash benefits or other financial assistance	64	26	26	38	
Family case management	43		13		
Referral to services	16				
Social/psychological services for people with mental health					76
Specialist health care				13	76
Disability services for children		15		11	82
Alcohol and substance abuse treatment		15	17	11	83
Parenting education		17			

Source: NORC evaluation survey

Social workers, through self-assessment, believe they are effective in family strengthening and stabilization: On average, the majority of the respondents (68%), felt that all of the activities undertaken by social workers are “very effective” in strengthening and stabilizing families. This includes case management, assessments, case or care planning, decision making with the family/child, psycho-social counseling, referral to other services, monitoring visits in the office and home, direct support with financial or other materials assistance, and accompanying the family to other services. Of the activities listed above, the one considered less effective relative to the others is psycho-social counseling with 55% of respondents considering this activity to be “very effective” and 42% considering it to be “somewhat effective.”

Substantial training of project stakeholders: P4EC has conducted numerous trainings of project stakeholders since the start of the project. Table 4.3.3 below shows the summary data on the target group that has been trained, the number of people trained (disaggregated by gender) and the technical area in which they have been trained. Overall, P4EC has provided training sessions for 261 members of the Advisory Boards of Children (ABC), 1,310 community social workers or members of the SAFPD, 2,003 members of the multidisciplinary teams, 69 residential care center staff, and 230 staff of schools.²¹

Table 4.3.3: Training of Stakeholders across Technical Areas

Target Group	# Days	# People	# Women	# Men	Sample Technical Areas
ABC	20	261	192	69	-Monitoring and evaluation of social services for children -Children's rights -Summer school -Monitoring and evaluation of Foster Care service in Calarasi district
CSW/SAFPD	57	1310	1129	179	- Organization and management of Foster Care service - Family Support service - Strategic planning workshop with new districts on child protection - Strengthening Families program
Multidisciplinary team training	61	2003	1603	401	-Law on special protection of children -Inter-agency cooperation mechanisms -Strategic planning workshops
RCC staff	6	69	54	15	-Change management workshop
School staff training	20	230	225	5	-Development of inclusive education

Source: P4EC administrative data

Conclusions:

The status of vulnerable families and the child care and protection system to support them and prevent the separation of children at the start of the P4EC program is summarized in the following points:

Vulnerable families face employment difficulties. Vulnerable families suffer from a lack of jobs in Moldova and find it difficult to have enough finances to stay in the country to care for their children instead of

²¹ Note that these figures do not represent the number of unique individuals trained as the same individual may attend more than one training on different topics related to his/her position.

leaving their children behind and migrating to find work. While social assistance is widely available, it is difficult to access and is not felt to be sufficient to cover their needs.

Not enough childcare services exist to enable parents to work full time. There aren't enough child care services at the community level, such as before and after school programs and day care, to allow parents to work full time.

Child care and protection services somewhat adequate and family support is somewhat effective. On average, child care and protection services were rated as only somewhat adequate and family support services as only somewhat effective at improving caregiving. However, respondents did feel that the system was very effective at strengthening and stabilizing families. Those services that were thought to be the most effective were cash benefits or other financial assistance, family case management, and referral to services. Services most needing improvement were alcohol and substance abuse treatment, disability services for children, social/psychological services for people with mental health issues, and specialist health care.

Families with disabled children are especially struggling. Parents are not able to maintain a steady job because they need to care for their disabled children and the social assistance provided is not enough to allow them to stay at home to provide the care. Moreover, services for children with disabilities are not widely available across communities and need improvement.

Services are less adequate and accessible to those with substance use/abuse problems, ethnic minorities, and teenage parents. Substance use/abuse is a major issue among families and the existing services are not meeting the needs because they are not widely available or effective.

Prevention services are very important. Early intervention and prevention services such as emergency services, services for mother-child, diverse services such as other kinds of foster care, and parental education were viewed as very important to ensuring children remain in their families.

Question 4: Did the program bring out systemic changes at the community, regional, and national levels that are enabling children to live in family care and preventing inappropriate placements in institutional care?

Sub-questions:

- a) Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation: and promote appropriate family care for children without parental care?
- b) Is there an improvement in caregivers' parenting skills and practices?
- c) Is there any change in attitude towards residential care among parents, extended family and community members?

Findings

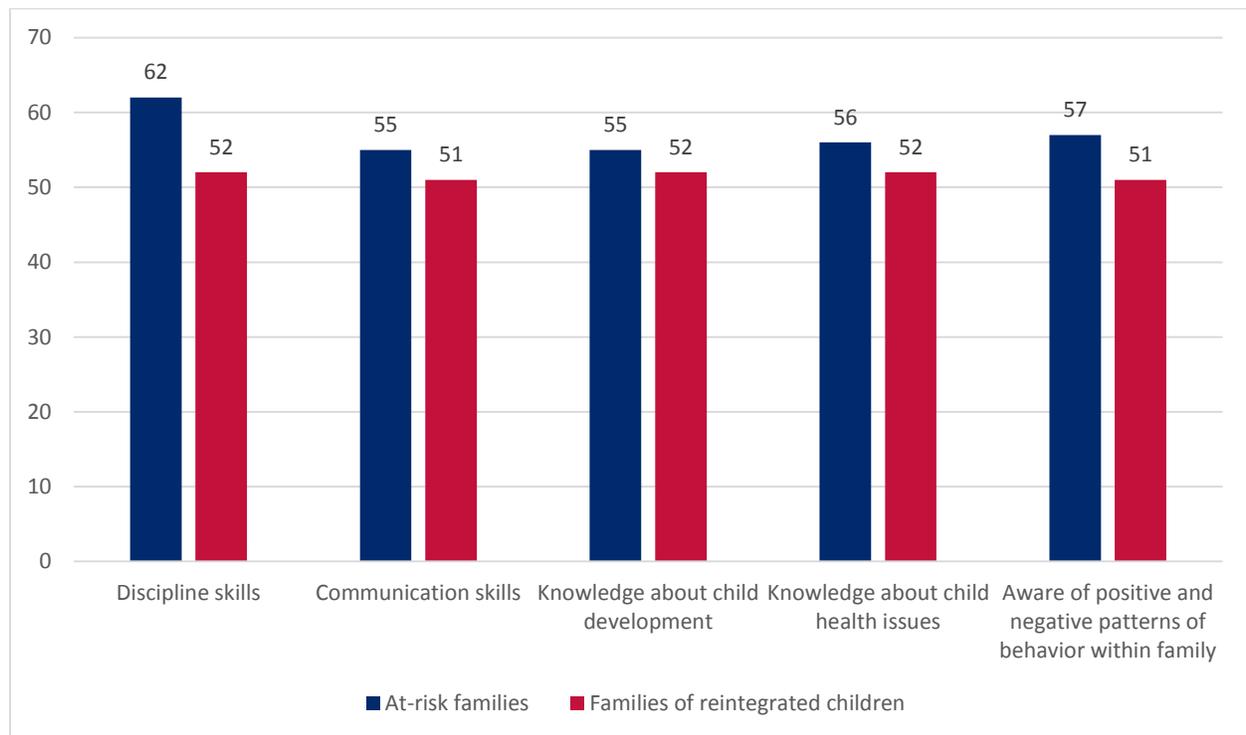
Survey respondents believe existing national policies and legislation are being adequately implemented to support the functioning of the child protection system. Community social workers and social work specialists were asked in the survey if they agree or disagree that existing national policies and legislation are being adequately implemented to support the functioning of the child protection system. In the evaluation survey 35% of all respondents said that they "strongly agreed" and 57% said they "somewhat agreed." Another 28% stated that they "strongly agreed" and 66% "somewhat agreed" that the child care and protection system functions as well as it is supposed to. In the key informant interviews, the

policies most frequently mentioned as important were the Inter-Sector Cooperation Mechanism, Law 140, Law on Social Assistance, National Strategy for Child Protection, National Strategy on Restructuring the Residential System, and the National Strategy for Inclusive Education (key informant interviews)

In the survey, the top three areas of child care and child protection that need improvement were identified as service development and implementation (52%); resource allocation at the raion and local level and an adequate workforce to protect children (each at 49%); followed by resource allocation at the national level (46%). Additionally, key informants interviewed felt that there is a need for further alignment of the laws, for example the Family Code with Law 140.

Individual one-on-one parenting education with social workers most effective at improving parenting skills. According to majority of social worker respondents to the evaluation survey, “most” of the vulnerable parents and parents of reintegrated children have the necessary skills to look after their child. As seen in Graph 4.4.1, there was not much difference between the two types of families in the individual parental skills except for in the case of discipline skills where more social workers felt vulnerable families had discipline skills (62%) than families of reintegrated children (52%).

Graph 4.4.1: Respondents stating that "most" of these caregivers have the following skills (%)



Source: NORC evaluation survey

Additionally, when asked which of the following methods are most effective for increasing parenting skills and knowledge (see Table 4.4.1), about half the respondents(51%) felt that individual one-on-one parenting education with a social workers was “very effective” followed by parenting classes/workshops (41%) and support groups (39%). Written resources are considered as the least effective methods for increasing parenting skills and knowledge.

Table 4.4.1: Effectiveness of methods in increasing parenting skills and knowledge (%)

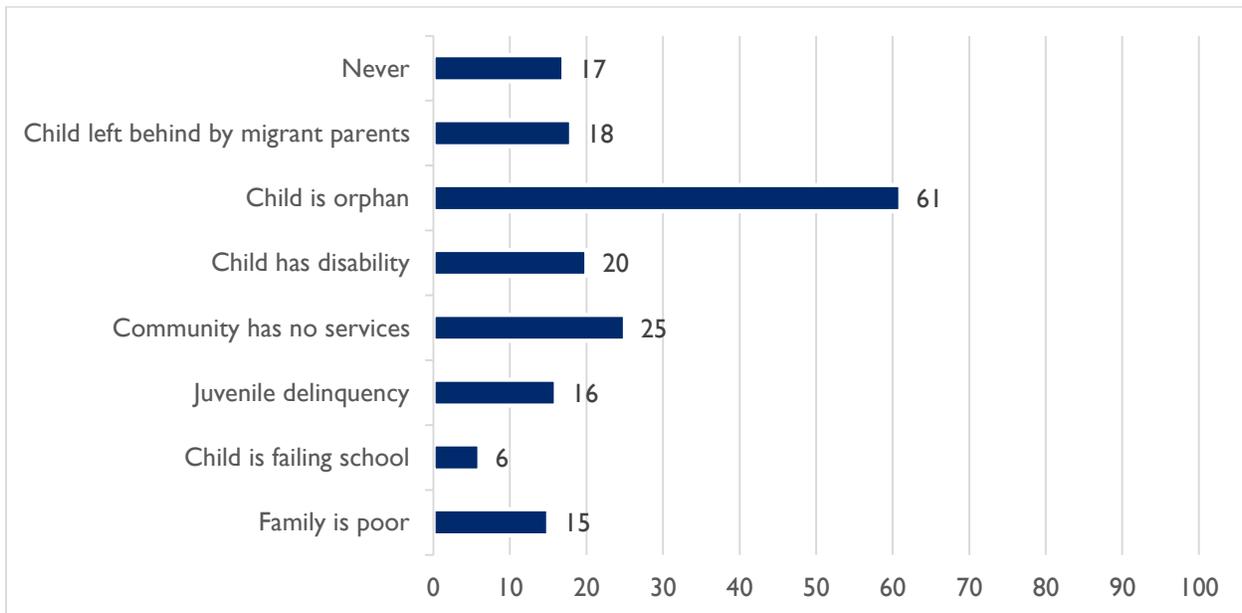
Q84: How effective are each of the following methods for increasing parenting skills and knowledge for the families with whom you work?	Very effective	Somewhat effective	Not at all effective
Individual/one-on-one parenting education with a social worker	51	48	0
Parenting classes/workshops	41	53	3
Parent support groups	39	54	3
Books, magazines, and other written resources	27	58	13

Source: NORC evaluation survey

Belief that there is still a role for RCCs. According to the results of the evaluation survey, there is still widespread acceptance of residential care facilities. As shown in Graph 4.4.2, the largest percent of social worker survey respondents (61%) felt it was appropriate to place a child in a residential care facility in cases where the child is an orphan. Only 17% felt it was never appropriate. Focus group participants did indicate that views on the appropriateness of placing a child in an RCC have changed from prior attitudes and practices. According to the focus group respondents, previously, if a child was separated from his/her parents for any reason (e.g., death) the child was placed in a RCC, even if there were relatives willing to take him/her in. Now they take the opposite approach and try to find a solution within a family (focus group with Soroca mayors).

On the other hand, as demonstrated in the focus groups, in cases of children with severe mental disability, many of those from within the child care and protection system felt that it was best for them to be placed in an RCC (6 focus groups with community social workers, social work specialists, multidisciplinary teams, gatekeeping commissions, and mayors).

Graph 4.4.2: When might it be appropriate to place a child in a residential care facility? % answering "Yes"



Source: NORC evaluation survey

In Table 4.4.2 below, respondents share their perception on the extent to which residential care is considered acceptable by parents and by the community; 25% of social worker survey respondents felt that “most” parents believe that residential care is acceptable for their children, and 56% felt that “some” parents believe that residential care is acceptable for their children. Regarding the communities’ acceptance and support for residential care, 61% of respondents felt that “some” community members believe that residential care is a good service to care for children; and 43% stated that “most” community members are supportive of deinstitutionalizing children.

Although key informants interviewed felt that public attitudes are slowly changing, focus groups showed evidence of the continued idea that RCCs are suitable alternatives when the child must be separated from his/her parents. Some examples given by focus group respondents were when children are beaten by parents or otherwise badly treated, when parents don’t have enough money to provide food or clothing, when children are orphans and have no family (6 focus groups with children, 1 with parents, and 1 with community social workers). Additional reasons felt as acceptable were when the child has severe behavioral problems and the parent cannot control him/her (focus group with mayors), when the child has cycled through many different families and social services with no successful placement (2 focus groups with children and parents), and if the child has been in an RCC since he/she was a baby or very young (focus group with children).

According to key informants interviewed, an important element to fully transition attitudes is for people to perceive that alternative services are working.

Table 4.4.2: Acceptance and support for Residential Care (%)

Acceptance and support for residential care	All	Most	Some	None
To what extent do parents believe that residential care is acceptable for their children?	3	25	56	13
To what extent does the community believe residential care is a good service to care for children?	4	28	61	5
To what degree is the community supportive of deinstitutionalizing children?	10	43	43	4

Source: NORC Evaluation Survey

Respondents believe that an RCC is not good for children. In support of the survey findings that only some parents believe RCCs are acceptable for their children, the majority of focus group respondents felt that RCCs are not a positive place for children. The reasons given included: children have no family or parental ties (10 focus groups with children, and gatekeeping commissions); they don’t receive enough individualized attention from adults (3 focus groups with children, parents, and gatekeeping commissions); they risk being beaten up (6 focus groups with children); they are lonely (4 focus groups with children) and as a result they often run away (9 focus groups with children, community social workers, and social work specialists).

“When a child lives in an institution he does not learn life skills or how to care for himself. Children in institutions become dependent on services” (Social worker specialist, Telenesti)

Children are sometimes put in placement centers long term. According to key informants interviewed, particularly in raions in which P4EC had not previously worked, there is placement of children in group care – placement centers – for longer periods, more than a year in some cases. According to focus group respondents, there is an attitude among some that placement centers are similar to RCCs in that they are a long-term placement option (4 focus groups with children and parents).

Negative stereotypes of children in RCCs. Some common perceptions of children in RCCs reported in focus groups are: they don't have a good upbringing and have behavior problems such as smoking, abusing drugs, drinking, and spending time at the disco (7 focus groups with children, parents, and mayors); they are uneducated or less intelligent (6 focus groups with children and mayors); and they have some type of illness (4 focus groups with children). Other perceptions are that they are poor, beaten, and commit crimes (2 focus groups with children) they are tormented at the RCCs and made to do hard work; or they are sad and closed off from people (focus group with children).

Children in focus groups generally felt the public has pity for children in RCCs (4 focus groups with children) and thinks they should be helped (5 focus groups with children). An idea from child focus group respondents on how to change this perception of children in RCCs is to increase interaction between children from RCCs and those who have not been admitted to an RCC in order to understand them better and decrease indifference towards them (2 focus groups with ABC children).

An attitude found among some mayor focus group respondents regarding problem children from vulnerable families or in RCCs was that children are fated to repeat the behaviors of their parents and if they come from a family where the parent(s) are viewed as engaging in socially unfavorable behavior then the child will inevitably follow in their footsteps.

"...but she is a very difficult child, from the eighth grade she started to have sexual relations with boys, but this tradition comes from the family, you know, something transmitted as heritage, some of this stuff ... And we marked her with red and keep the eye on her...It is interesting to see if she wants to go somewhere with her brothers or maybe to a special school, where she will be accommodated, cared well, so she can graduate the school, if she wants further to have a normal life, but if not... we may take something from someone using the physical power, but to give..." (Mayor from Soroca)

"M7: We all have a problem, that problem is that we should care for the child till 18 years old, what happens next? He is exactly the same as his parent, reaching majority he remains as evil as he was.

M6: As you have said, he produces people exactly like him." (Mayors from Nisporeni)

Children from RCCs face challenges when integrating into public schools. In the focus groups, parents mentioned difficulties in performing well at school (getting good grades) when transitioning from an RCC to public school and that children get discouraged. Some mentioned that public school is more difficult than the curriculum in RCCs so children struggle to catch up (3 focus groups with parents); others mentioned a stigma from the teachers towards their children, calling them stupid to their parents, ignoring them in the classroom, and giving them low grades because they came from an RCC (4 focus groups with parents and 1 focus group with community social workers) ; and finally, others talked of difficulties in social integration with other children in the class, they are made fun of or insulted by others because they lived in an RCC (4 focus groups with children, parents, and mayors).

"My girl tells me that she can learn but she sees no point in that, as she does not get a grade higher than five or six. When she has some tests, she tries hard and she notices that other children who make mistakes get a five and she gets a five too, though she has no mistakes. I have no objections to other children; my children get along with them. However, the problem is the teachers. My girl is always telling me that she does not want to study and that she does not even want to go to school. In that school, she was the head of the class and here she is at the bottom of the pupils' list. Although she tries to learn hard, she sees no motivation as the teachers treat her as a child who came from that school and she does not need a higher grade." (Parent from Singerei)

At baseline, some focus group respondents felt that deinstitutionalization was happening without preparation within society and structures. For example, public schools are not prepared to take children

with hearing or vision impairments²² (2 focus groups with mayors and social work specialists). Frequently the inclusive education reform and services are mentioned as critical to deinstitutionalization and successful school reintegration (key informant interviews).

“...we are not prepared. Our population is not motivated, the families are not motivated to do this program. Maybe the lack of finances and material basis, but anyway it is still not ready, we're not ready. So we went one step ahead, with the deinstitutionalization of children and the closure of these centers. We hurried, we had first to work here locally, to prepare, to have families, even biological families prepared to ..., the school prepared, the kindergarten if you want and why not the town hall community, the mayor, because we passed it, but ...” (Soroca mayor)

Attitude that children with mental disabilities should not be in public school. According to focus group respondents, it is believed that children with mental disabilities should not be integrated into public schools because they are not able to function at the same level as the other children and will be isolated (6 focus groups with parents, mayors, and multidisciplinary teams). Those with severe mental disabilities are believed to need their own special school; also in this category are deaf and blind children. (6 focus groups with community social workers, social work specialists, multidisciplinary teams, gatekeeping commissions, and mayors). Attitudes of teachers on this subject has changed; they are now more open and able to work with children with learning differences since the inclusive education strategy was adopted (key informant interviews).

“If it's about children with disabilities it is necessary of a family type alternative or the state, because you cannot integrate the one with disabilities to simple school. He must have his psychologist, some doctors; they have a certain level of knowledge. These pupils who came healthy in the class, they need to progress, the sick one must be educated only up to a certain stage, why should they receive information that they cannot assimilate.” (Nisporeni mayors)

According to focus group respondents, this does not mean these children need to be placed in RCCs:

“Parents can take them for a certain period in the respective centers to be trained and then take them back home in the family to feel the warmth of their home and not stay separated. So with children who have hearing disability, or sight problems, all these kids are not going to be able to go to that class, because of their disability and because of this I they cannot go with kids in usual schools. They are specially trained in those institutions for a certain period, and then, they taken into the family.” (Mayor from Soroca)

Possible to integrate children with physical disabilities if done at an early age. While focus group respondents largely focused on children with mental disabilities, one focus group with mayors from Nisporeni felt that a child with physical disabilities can be successfully integrated in school if it is done from an early grade. According to the focus group, while at first it will take time to be accepted, the adjustment happens at this young age and then from the remainder of grade school classmates do not isolate the child and instead start helping him/her.

Children play limited role in placement decision-making. According to focus group respondents, social workers are the main players regarding placement of a child. They are the ones who assess the situation once it has been reported. All efforts are made to solve the issues so that the child can stay within their family. If it is determined that the child must be separated from the family, the final placement decision is made either by the multidisciplinary committee or by the court, depending on the case (12 focus groups with children, parents, gatekeeping commissions, and multidisciplinary teams). Others involved in the decision-making are parents and other relatives (8 focus groups with children, gatekeeping commissions,

²² Note that children with hearing impairments are not being deinstitutionalized by the project.

and multidisciplinary teams). In some cases, the child may be asked his/her opinion if he/she is over 14 (5 focus groups with children and multidisciplinary teams). Others felt that children are not asked their opinion about placement (4 focus groups with children and parents).

“In cases where parents are divorced and the child is older, he can choose, there is a period when a decision is made and then a child is asked who he wants to be with – his mom or his dad. In cases where a child is taken to an orphanage and the parent is deprived of their parental rights, then there is no point in asking the child about his opinion, I mean he has no one to stay with him. Even if he can stay with his relatives, he is anyway first taken to the orphanage and then relatives can take him.” (Boy aged 12 to 14 from Nisporeni)

Children’s voice should be heard. A particular message of a few focus groups is that children of any age should be consulted with and listened to (6 focus groups with children, parents, and social work specialists).

“Parents should assume all responsibilities for their child. [They] should love their own child and to attract them more attention and to listen to what they want, because each child has his own opinion and he also wants to say his opinion. And when the child is listened to he feels better and says he has [someone] to whom to turn to.” (Orhei girls 15 – 17)

“They [social worker] should come to see them. Ask them what they need. To consult [with] the children, not only ask their parents. They call and ask only the parent. He calls me and asks me what my girl needs. Let them come and ask the child. She’s mature enough. She can answer to all the addressed questions. Let’s ask her what she needs. She needs to learn somewhere, to go somewhere to study. Maybe she wants to be dressed better than how I am able to dress her.” (Orhei parents)

According to focus group respondents, the Advisory Boards of Children (ABCs) play an important role in having the child’s perspective and voice heard. Their mandate is to monitor and defend children’s rights. They collaborate with community social workers and conduct home visits. They are respected and their opinions are valued in Calarasi and Cahul (2 focus groups with ABC children).

Chi-Square tests of independence: We examine if the functioning of the child care protection system is independent or correlated with the adaptability of deinstitutionalized children. To capture social workers’ opinion on the child care and protection system, we use the question: “Do you agree or disagree that the child care and protection system functions as well as it is supposed to?” The response options are: “strongly agree”, “somewhat agree”, “somewhat disagree”, “strongly disagree”. The question on adaptability is: “In general, are the children who have been deinstitutionalized in your raion/community adapting well?” The response options are: “mostly”, “somewhat”, and “not at all”. The Chi-Square tests show that that deinstitutionalized children’s adaptability is strongly correlated with social’s workers opinion of the functioning of the childcare and protection system. The strong correlation however, does not indicate causation.

Conclusions

Community social workers and social work specialists believe that existing national policies and legislation are being adequately implemented to support the functioning of the child protection system. The policies most frequently mentioned as important were the Inter-sector Cooperation Mechanism, Law 140, Law on Social Assistance, National Strategy for Child Protection, National Strategy on Restructuring Residential System, and the National Strategy for Inclusive Education (key informant interviews). The top four areas of child care and child protection that need improvement were identified as service development and implementation, resource allocation at the raion and local level, an adequate workforce to protect children, and resource allocation at the national level.

Individual one-on-one parenting education with a social worker most effective at improving parenting skills. According to social workers, about half of vulnerable family parents and parents of reintegrated children have the necessary skills to look after their child. For those needing parenting education, individual one-on-one parenting education with a social worker is the most effective but parental education services are lacking in availability (see Q1 findings).

There is still widespread acceptance of residential care facilities. RCCs are viewed as an acceptable form of care for children by social workers in cases when the child is orphaned or when the child has a severe mental disability. The majority of social workers believe that some parents and some community members think RCCs are acceptable for children, yet most are supportive of deinstitutionalizing children and believe RCCs, while acceptable in certain circumstances, are not a positive environment for children.

Children in and from RCCs suffer from negative stereotypes. A common perception of children in RCCs is that they don't have a good upbringing and have behavior problems such as smoking, abusing drugs, drinking, and spending time at the disco; that they are uneducated or less intelligent; and that they have some type of illness.

Children from RCCs face challenges when integrating into public schools. When they are deinstitutionalized, the negative stereotypes create challenges to integrating into the public schools. Other students treat them badly and even the teachers discriminate against them.

Attitude that children with mental disabilities should not be in public school. It is believed that children with mental disabilities should not be integrated into public schools because they are not able to function at the same level as the other children and will be isolated. Those with severe mental disabilities should attend special day schools and their parents should be trained so that they can continue to be cared for in their families instead of being sent to an RCC.

Children play a limited role in placement decision-making. Some people felt children may be asked their opinion about placement if they are over 14 while others thought children are not asked their opinion at all. In either scenario, the child's opinion does not play central role in placement decision making. A central message communicated by children and some parents and social workers is that parents and social workers should consult and listen to children of any age. The Advisory Boards of Children (ABCs) play an important role in having the child's perspective and voice heard.

Question 5: By project end, to what extent have functioning structures been established that can continue to provide on an ongoing basis adequate case-management services for children at risk?

Sub-questions:

- a) Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?
- b) Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?

Awareness and support for child protection services at the raion level: A majority of the evaluation survey respondents, 64%, strongly agreed that the raional council is aware of national child protection policies. Focus groups with mayors, social work specialists, and community social workers showed that they were all very familiar with Law 140, the mayors in particular cited the law and were familiar with the associated procedures involving the multidisciplinary teams. The exception were community social

workers in Singerei who did not mention the multidisciplinary team or coordination/collaboration with other actors in the case identification and assessment process.

A majority of the evaluation survey respondents also strongly agreed (51%) that the raional council is supporting improvements in the child protection system (see Table 4.5.1 below). When asked “does the raional council make financial resources available for child protection?” 88% answered “yes”; of the remaining 12%, 8% said “no,” and 4% either refused to answer or did not know. Similarly when asked “to your knowledge are services for children and families included in the raional budget?” 86% answered “yes”; 3% answered “no”; 10% “refused”; and 1% said “don’t know.”

Almost all respondents, 95% said that their raion has a child protection service development strategy. According to respondents the top three areas in which raional child protection service development strategy requires improvement are (1) “strategy should include plans for increased budget allocation,” (89%) (2) “strategy needs to reflect local needs and realities,” (87%), and (3) “strategy should include plans for development of services,” (87%). Key informant interviews supported this finding in that few districts currently have social service development but contradicted the first finding, instead showing that few districts have child protection strategies. Some are working on them now, and some have strategies that have expired. This was mentioned as an area where the project is helping.

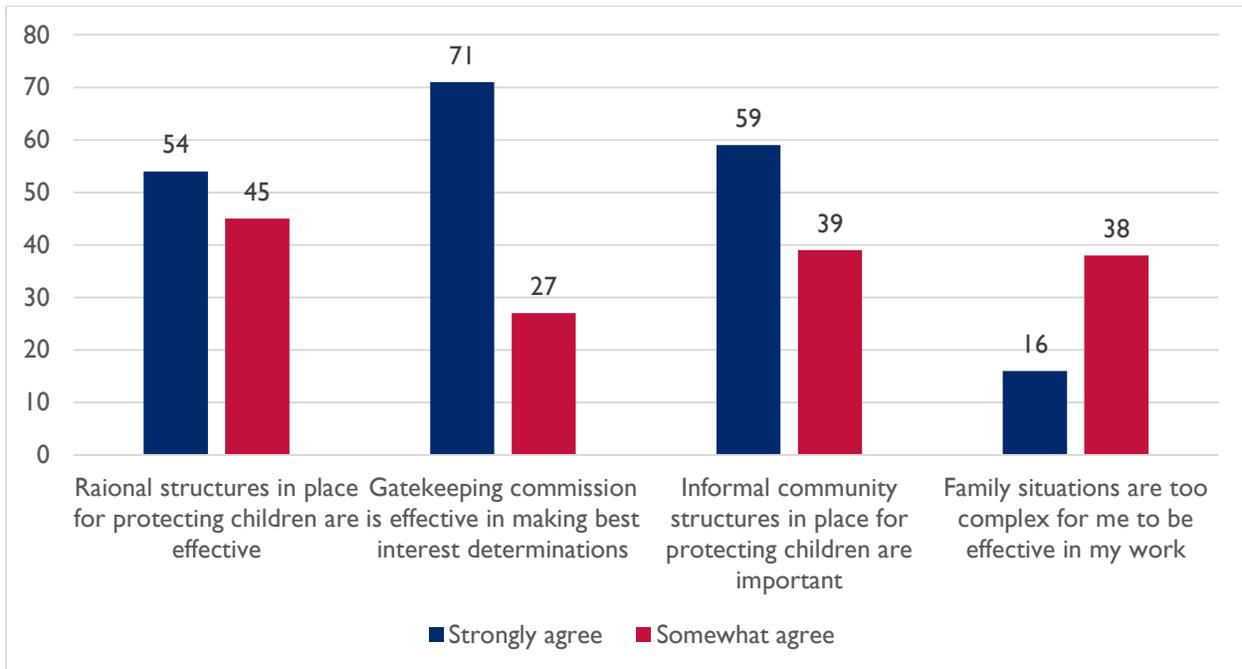
Table 4.5.1: Support and Awareness of Child Protection Systems (%)

Support and Awareness of Child Protection Systems	Strongly Agree	Somewhat Agree
Do you agree or disagree that the raional council is aware of national child protection policies?	64	34
Do you agree or disagree that the raional council is supporting improvements in the child protection system?	51	46

Source: NORC evaluation survey

Existing structures are effective in child protection: Graph 4.5.1 below shows evaluation survey respondents’ feedback on the effectiveness of structures and situations that affect child protection. Gatekeeping commissions are viewed as being most effective (71% “strongly agree”), while raion and community structures are seen by social workers as effective, but less strongly so (54% and 59% respectively “strongly agree”). Complex family situations are only seen as affecting the effectiveness of social workers work by about half of the respondents, and only 16% say it does so strongly.

Graph 4.5.1: Structure/situations Impacting Effectiveness of Child Protection work (%)



Source: NORC evaluation survey

Social workers are aware of job responsibilities: As shown in Table 4.5.2, while 88% of social workers said that they understand the role and responsibilities of their job, only about two thirds felt supported in their job (65%), and felt that their supervisor provides support that helps them do a better job (69%). This result was supported by 3 focus groups with community social workers and social work specialists who felt that most of the responsibility falls on their shoulders. Again in Table 4.5.2, the percentage of respondents who are “very confident” about their ability to do a good job in each area of their work” varies from a high of 83% for “making home visits,” and 81% for “working one-on-one with client in my office;” to a low of 48% for “representing clients in court.” Additionally, nearly 50% felt the social work workforce is “highly skilled and knowledgeable” to adequately protect children and fully support vulnerable families. Survey respondents were asked, “which of the following are part of your job responsibilities;” 90% or more agreed that the following are included in their job responsibilities: identifying clients, completing assessments, interviewing/talking with clients, developing care/service plans, referrals to other service/organizations, representing cases in the gatekeeping commission, completing paperwork for government assistance, making home visits, working on-on-one with clients in my office, work with adult children, working with child clients, and completing reports to my supervisors. Much smaller shares of social workers agree that these functions are included in their job responsibilities: (1) supervising other workers (46%), (2) representing clients in court (70%), and (3) running group sessions for clients (73%).

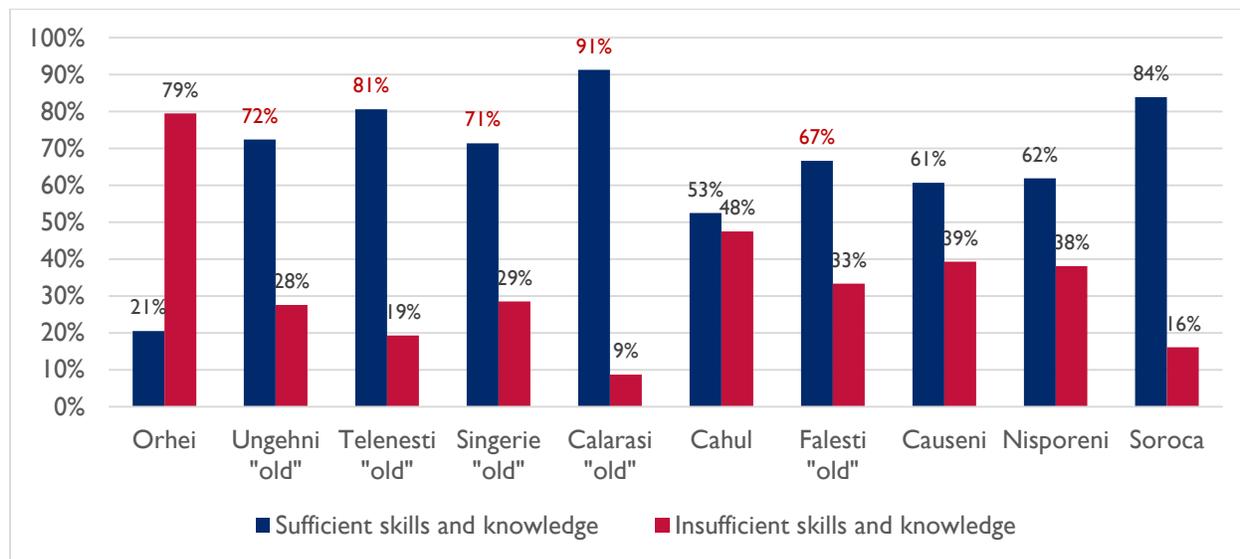
Table 4.5.2: Social worker opinions on preparedness for their job (%)

Q60: Do you agree or disagree with the following	Strongly agree	Somewhat agree
I understand the role and responsibilities of my job	88	12
I feel supported in my job	65	33
My supervisor provides support that helps me to do my job better	69	27
Q62: How confident do you feel in your ability to do a good job in each of the following areas of your work?	Very confident	Somewhat confident
Identifying clients	60	40
Completing assessments	74	26
Interviewing / talking with clients	68	31
Developing care / service plans	54	44
Referrals to other services/organizations	57	42
Representing clients in court	48	47
Representing cases in the gatekeeping commission	71	27
Completing paperwork for government assistance	70	26
Making home visits	83	17
Working one-on-one with clients in my office	81	19
Working with adult clients	72	27
Working with child clients	74	26
Running group sessions for clients	52	44
Completing reports to my supervisors	69	29
Supervising other workers	61	35
Q67 + Q68 To what extent do you believe that the social work workforce in your raion/community has the necessary skills and knowledge to:	Highly skilled and knowledgeable	Somewhat skilled and knowledgeable
Adequately protect children?	48	51
Fully support vulnerable families?	48	52

Source: NORC evaluation survey

In the KAP survey conducted by P4EC, a majority of social workers across all 10 raions (63%) felt they had sufficient skills and knowledge to cope with their job responsibilities; while 37% felt they had insufficient skills and knowledge, and 47% felt they do not know their job roles and responsibilities. As seen in Graph 4.5.2 below, between 67% and 91% of social workers in the “old” raions feel they have sufficient skills and knowledge. Among the “new” raions 84% of social workers in Soroca feel they have sufficient skills and knowledge while 79% in Orhei feel they have insufficient skills and knowledge.

Graph 4.5.2: Skills and knowledge of social workers to undertake job responsibilities (%)



Source: P4EC Knowledge Attitudes and Practice survey 2015.

Mixed knowledge among social workers regarding protection measures in case of child abuse: The KAP survey undertaken by P4EC shows that community social workers have varied knowledge regarding protection measures to follow after identifying a case of abuse or maltreatment of children. Those in Falesti, Soroca, Ungheni, and Singerei were able to identify appropriate measures (referral, collaboration with the mutli-disciplinary team, opening a case file, case management procedures, development of the individual assistance plan, removal of the child from the family if he/she is found to be at high risk, working with leading specialist in the CSAS, etc.). However, community social workers from Causeni, Nisporeni, Calarasi, Orhei and Telenesti showed some gaps in their knowledge. There was also mixed knowledge among social workers regarding how professionals from education, health and police can help prevent and intervene in the cases of abuse. Those from Falesti, Soroca, Ungheni, and Telenesti mentioned inter-agency collaboration mechanisms; social workers from Causeni mentioned multi-disciplinary teams in case management; social workers from Nisporeni, Calarasi, Singerei interpreted the involvement of professionals from other fields in mainly prevention activities. Social workers from Falesti were most knowledgeable regarding this topic due to their involvement in the piloting of the inter-agency collaboration mechanism on child abuse and neglect. In the evaluation survey, when asked to mention one national child protection policy/legal act that is important for child protection in the raion/community a large majority, 79% listed Law 140 on the Special Protection of Children at Risk and Children Separated from Parents.

Strengths and gaps in knowledge and practice by other specialists: The KAP survey also asked other specialists involved in the provision of social and educational services for children and families questions regarding their skills, training and support needs. Table 4.5.3 below highlights the key strengths and gaps identified by the KAP survey.

Table 4.5.3: Strengths and Gaps of Specialists

Specialists	No.	Strengths	Gaps
Heads of CSAS	10	-Have self-reported a good knowledge of social care and child protection necessary for their responsibilities	-Identify their greatest knowledge gap in national social policies -Face biggest difficulties in organizing inter-sectoral collaboration to mobilize resources for beneficiaries
Staff within SAFPD	24	-Group of professionals with largest work experience	-Have only a broad knowledge of access to cross-sectoral help to prevent and resolve cases of abuse
Staff within PPAS	29	-Demonstrated knowledge on the concept of inclusive education	-Self-identified lower competence in the areas of developing recommendations on forms of child involvement in educational activities and organization of training process at home, monitoring school inclusion and child's progress, cooperation with governmental structures and NGOs on school integration of children and risk mitigation -Lack specialists to work with children with hearing and visual impairments
Members of the CPCD	84		-High turnover of CPCD members
Managers of social services	18	-Managers of centers have a better understanding of their managerial duties, work procedures, etc. compared to managers of TSAS.	-Need support in understanding current social policies and the organization of social assistance system at the national, district and local levels
LPA representatives	5	-Understand the needs of the population and are able to communicate with the population.	-Lack knowledge of the social assistance sector; limited knowledge of their responsibilities under this sector; and perception that this sector is relatively less important compared to others.

Source: P4EC report on the KAP survey. CSAS = community social assistance service; PPAS = psycho-pedagogical assistance service; CPCD = Commission for the protection of the child in difficulty; LPA = Local Public Authorities.

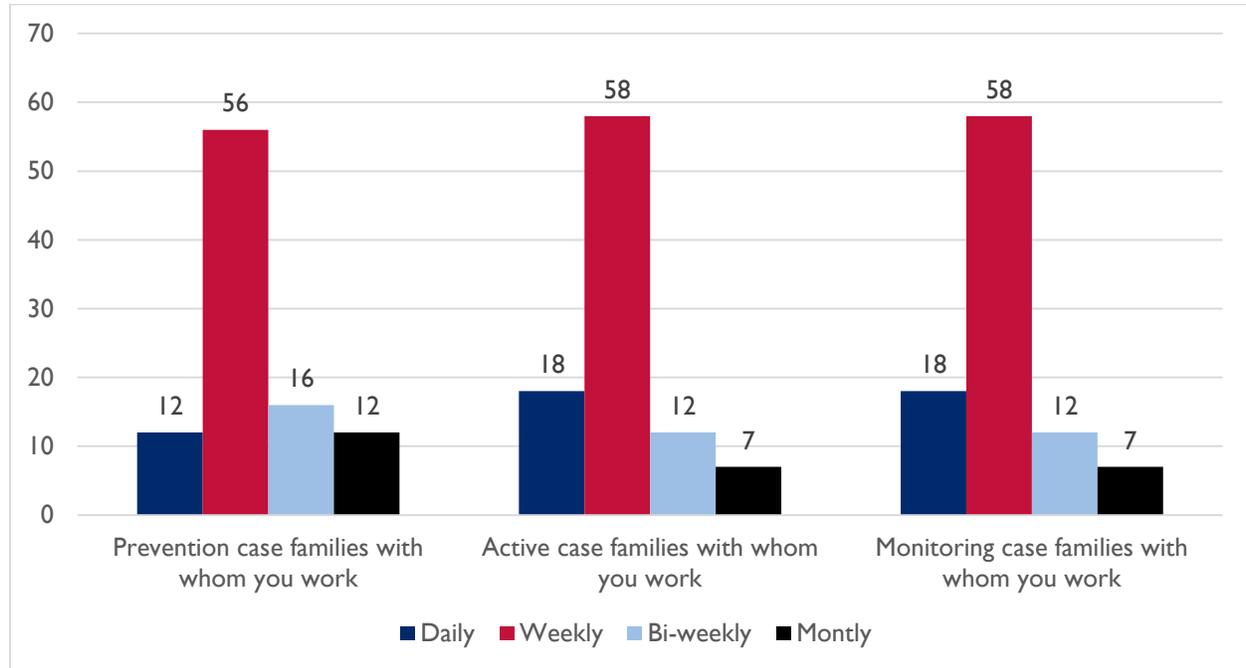
High workload affects social worker contact with families: Most of the social worker evaluation survey respondents make weekly contact with prevention (56%), active (58%) and monitoring case (58%) families that they work with (see Graph 4.5.3). Daily contact is made by only 12 – 18% of the respondents. The number of community social workers in each of the project's raions varies from a low of 31 (Calarasi and Causeni) to a high of 48 (Cahul). When asked "how often are you in a situation where you work overtime?" 14% replied "all of the time"; 31% replied "most of the time"; and 53% replied "some of the time." Only 2% replied "never."

Amongst the community social workers, the largest percent of respondents, (19%) state they have 2 active cases, followed by 14% that have 5 cases and another 14% that have 4 cases. This workload is different among the social work specialist due to their supervisory role – the largest percent (28%) have 2 active case; 14% have 50 active cases, and 8% have 30 active cases.²³ Only 19% of all respondents said that they "always" have enough time to visit with the families they work with; 61% said that they had enough time "most of the time"; and 17% said it was enough time "some of the time." The top three factors that prevent community social workers and social work specialists from having enough time is "paperwork that has to be completed," (96%); "lack of transportation (family or worker)," (64%); and "location of the family," (59%).

²³ Note that the total number of community social workers in our sample is 264; and social work specialist are 36.

One of the challenges mentioned by 2 out of the 4 focus groups with community social workers was they don't have the status of a civil servant and so they don't feel that they have enough authority or respect from the public to do their job.

Graph 4.5.3: Frequency of Contact with Families (%)



Source: NORC evaluation survey

Insufficient resources for community and social specialists: As seen in Graph 4.5.4, fewer respondents “strongly/somewhat agree” that logistical/financial resources are available relative to professional resources. The results below are also confirmed by another question asked to respondents. Of those saying that there are financial resources in place to support the functioning of the child care and protection system, only 47% listed the availability of office space; 46% the availability of family contingency funds; 45% said financial resources for workforce hiring, training; 44% said financial resources for services; and 35% listed the availability of transportation. This is confirmed by the focus groups. Three out of the 4 focus groups with community social workers mentioned the issue of not having a space in which to operate and receive families and three spoke of the lack of funds to finance specialists. In Soroca the community social workers said they needed a specialist in child rights protection at the community level but that the mayoralty had no funds to hire one. Both focus groups with social work specialists and 2 out of the 4 focus groups with community social workers felt that they were not paid a high enough salary for the work that they do.

Regarding professional resources, key informants interviewed felt the lack of the child protection specialists is a major issue that is linked to a lack of budget mentioned by most stakeholders. Budgetary problems were also blamed for the lack of services and inability of the district and communities to change. Lastly, turnover of community social workers was widely cited as the top issue for social work with vulnerable families/children (key informant interviews).

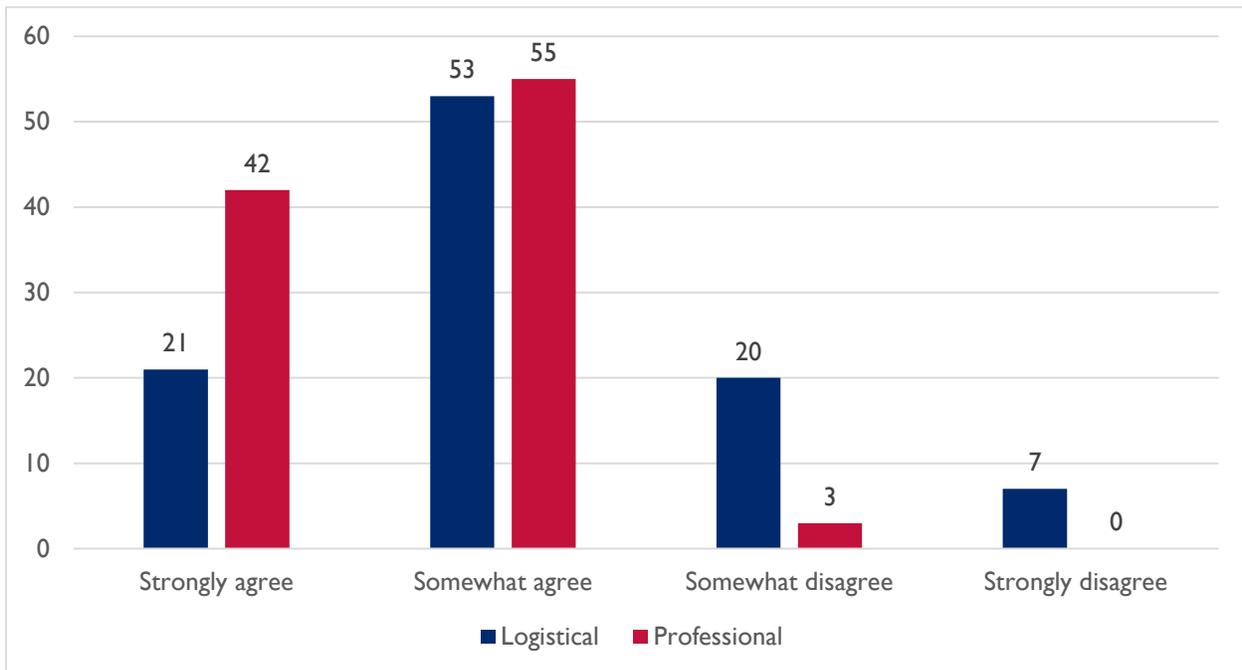
Both focus groups with social work specialists highlighted that they receive a lot of training but what is missing is joint training of the multidisciplinary teams. This would help clarify roles and responsibilities and strengthen the relationships. Additionally, key informants interviewed felt ongoing training for

community social workers, mayors, and RCC staff could be a way in which the project can continue to support knowledge development and change in attitudes.

“F6: We are spoiled with trainings, a thing which differentiates us from colleagues from other areas. You have to be always informed, learn news, and the trainings are welcome. We would like to meet with colleagues from various raions at trainings or even with specialists from other areas: from child protection, local police, doctors, and teachers. We would like a joint training. Very rarely we have trainings in teams of specialists; usually there are only workers from the social [assistance].

F7: Joint training and gathering would help us have a common language and every one of us would adapt his language. We would be more responsive. We work with papers but we didn't know each other and when we met our collaboration became more fruitful.” (Social work specialists from Falesti and Ungheni)

Graph 4.5.4: Availability of Logistical/Financial and Professional Resources (%)



Source: NORC evaluation survey

Medium level of cooperation and collaboration between service providers: According to social worker survey respondents, the highest coordination/collaboration is seen between raional child protection actors and local actors to meet the child care and child protection needs of families (61%), followed by raional/local government and NGOs (38%) (see Table 4.5.4). A fifth of respondents felt that there was “low” or “no coordination/collaboration” between the national government and raional/local government. This finding is supported by key informant interviews where some felt that coordination at the national level is lacking and others felt it improved; collaboration at the national level and between the national and raion level is described as “functional” and “adequate”. Additionally, key informants interviewed from all raions spoke about collaborating with other raions and calling upon each other for help and advice.

Table 4.5.4: Extent of Coordination and Collaboration between Stakeholders to meet Child Care and Protection Needs of the Family (%)

Q40: What is the extent of coordination and collaboration between the following actors toward meeting the needs of families?	High Coordination/ Collaboration	Medium Coordination/ Collaboration	Low Coordination/ Collaboration	No Coordination
Raional/local government and non-government actors	38	50	11	1
National government and raional/local government actors	27	50	16	4
Raional child protection actors and local actors	61	36	2	0

Source: NORC evaluation survey

About half of the evaluation survey respondents (53%) “strongly agree” that they are able to call on the support of other service providers in order to provide integrated care to families; 45% “somewhat agree;” and 2% “somewhat disagree.” The service providers considered highly valuable are health clinics (93%), the police (95%) and schools/teachers (95%); however, the services considered to be most difficult to arrange are health clinics (21%), domestic violence services (14%) and the police (13%). The service providers that provide the weakest support are mental health services (28%), community organizations (23%) and churches (39%). This finding is supported by key informant interviews where medical professionals were viewed as the least likely to collaborate on the inter-sector mechanism. Additionally mayors were viewed as the least engaged group – they were described as ill-informed and resistant, evidenced for example by not showing up for training (key informant interviews).

Civil society organizations are also considered to be sufficiently engaged in protecting children from violence, abuse, exploitation or neglect – 81% of respondents felt that they “strongly or somewhat agreed” with this; and 78% “strongly or somewhat agreed” that civil society organizations are sufficiently engaged in preventing separation of children from families.

Multidisciplinary teams are a core mechanism for a joint approach to build family resilience, involve, support, and protect children. As per Law 140, multidisciplinary teams have been created in each community. This is the core mechanism through which the various sectors (mayor, school, police, social workers, health providers, and possibly psychologists) coordinate and collaborate. According to the focus group respondents, the main players are the mayor and the community social worker – whoever is notified of a case first informs the other. The mayor is the convener of the team and is the one to issue any decision regarding next steps for the case. The social worker writes up an initial assessment, which is discussed by the multidisciplinary team that then develops an intervention plan with a timeline. The sectors involved (e.g. police if there is domestic violence), implement the plan. The multidisciplinary team meets again based on the timeline in the intervention plan to determine if the case has been resolved. If it is not yet resolved, the team discusses the next steps.

Multidisciplinary teams (currently being trained under the project) were mentioned by almost all stakeholders among key informants interviewed as an important new actor in community-level child protection (key informant interviews). Focus group respondents viewed multidisciplinary teams very positively as a means to engage all members of the community to work together from different perspectives to protect and care for children (8 focus groups with gatekeeping commissions, mayors, multidisciplinary teams, and community social workers). They felt that people from a variety of disciplines are trained to resolve cases – Soroca mayors mentioned even involving neighbors and relatives to resolve a case and prevent placement of the child in an institution. They felt it was an efficient system where problems are solved more quickly because of collaboration across sectors and all

those involved take responsibility to resolve a case rather than passing on the responsibility between the sectors.

“[The creation of the multidisciplinary team serves] namely not to create in the community that atmosphere of indifference to the child, to vulnerable families, to those who fell into trouble in a specific moment; that the society [is] not to be indifferent, the town hall.” (Mayor from Nisporeni)

“It happens sometimes that a specialist in a particular field knows information about a case which other specialists don't know, and this collaboration helps to solve the case.” (Member of gatekeeping commission from Orhei, Calarasi, or Nisporeni)

A criticism of the mechanism from focus group respondents was that the procedure spelled out by the law is not necessarily followed. Two focus groups mentioned that the whole multidisciplinary team does not go together to investigate the situation, only a few members who are typically the social worker and the mayor (Soroca mayors and social worker specialists from Orhei, Calarasi, and Nisporeni)²⁴. Focus group respondents felt that sometimes it is difficult to work across the sectors as some are reluctant to spend the time to get involved in a case (3 focus groups with community social workers and social worker specialists). Key informant interviewed felt that the planned training (part of the P4EC project) would raise involvement of various professions.

“As my colleague from Calarasi mentioned, I would like to say that I feel ashamed to say it but I will: the evaluations are not made on the basis of the decisions made by the mayors, though most of them know they have to do it. The assistant learns about a case and – I hope not only by telephone but also in person – he makes the evaluation and registers it in the journal and then he goes on his own there as other people don't care much or are very busy – the mayor is busy, the medical assistant is busy – though there is Law 82 regarding children's mortality, according to which the medical assistant is obliged to provide children under 5 with the necessary assistance. And then the social assistant jumps over the fence and makes the initial evaluation” (SAFPD specialist from Orhei, Calarasi, or Nisporeni)

F7: There are no multidisciplinary teams.

F1: The cooperation between us and the multidisciplinary team more and more is invented and ruled by us. Not everyone is responsible for each specialist to be involved in cases.

F6: What if I need a specialist, I have to go search for him. If you cannot invite him, he is at his work. Each has his reason.

F7: It is an auxiliary work and they don't want.” (Community social worker from Soroca)

The gatekeeping commissions, raion-level committees composed of 7-9 professional members also from the same variety of disciplines as the multidisciplinary teams, were also mentioned by key informants interviewed as having an important role in preventing placement in RCCs. The complaint from focus groups was that members are unpaid but the workload is heavy and they believe they should be remunerated.

Chi-Square tests of independence: We test if the answers in question Q53 and the answers in Q56 are independent. Q53: How many active cases do you currently have? With Q56: On average, how often do you make contact with the monitoring case families with whom you work? The response options for Q56 are: *Daily, weekly, bi-weekly, monthly, every other month, less than every other month*. We found that the number of cases that a social worker has is correlated with how frequently the social worker makes

²⁴ According to P4EC, the whole multidisciplinary team should not be going to investigate the situation and what they report is how it should be, indicating a misunderstanding of how the procedure is supposed to work.

contact with the monitoring case families with whom s/he works. We found that this correlation is significant at 1% level. This implies a 99% confidence in the fact that the amount of case load of a social worker is going to affect how frequently they can monitoring their case families.

Conclusions

A majority of stakeholders feel that there is awareness and support for child protection services at the raion level. According to survey respondents the raion is supportive of improvements and provide resources for the child protection system. Almost all respondents say that their raion has a child protection service development strategy.

Existing structures are effective in child protection: Majority of CSW and social work specialists feel that existing rational and community structures and the Gatekeeping Commissions are effective in child protection. The complexity of family situations are also not considered to be a hindrance affecting the child protection work of social workers.

Social workers understand their job roles and responsibilities: Most feel supported by their supervisors, especially with respect to the availability of professional resources. Less are satisfied with the financial/logistical resources.

There is mixed knowledge among social workers regarding protection measures in case of child abuse: Community social workers have varied knowledge regarding protection measures to follow after identifying a case of abuse or maltreatment of children and how professionals from education, health and police can help prevent and intervene in the cases of abuse.

Collaboration among service providers critical to success of child care and support services: While cooperation and collaboration among raional stakeholders and multidisciplinary teams is considered to be high, some felt that is was less among the national and raion government. There were some criticisms regarding the smooth functioning of the multidisciplinary teams.

Question 6: Did the project offer models and approaches for expansion, adaptation, and/or replication?

Sub-questions:

- a) Were lessons learned widely discussed and disseminated during project implementation?
- b) Were any best practices or successful techniques institutionalized?

Since this evaluation question deals with project specific models and approaches and issues of sustainability we will present findings for this question only in the midline and endline evaluation reports.

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ANNEX I: CONCEPT NOTE

DRG LEARNING, EVALUATION, AND RESEARCH (DRG-LER) ACTIVITY

TASKING N003: CONCEPT PAPER

PERFORMANCE EVALUATION DESIGN OF USAID/DCOF'S CHILD CARE REFORM (MOLDOVA) AND FAMILY CARE FIRST (BURUNDI) PROJECT



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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

LIST OF ACRONYMS

DCOF	Displaced Children and Orphans Fund
DRG-LER	Democracy, Human Rights, and Governance Learning, Evaluation, and Research Activity
ESOMAR	European Society for Opinion and Marketing Research
FGD	Focus Group Discussions
IRB	Institutional Review Board
IRC	International Rescue Committee
JSI	John Snow Research & Training Institute
KII	Key Informant Interviews
LA	Local authorities
NORC	National Opinion Research Center
P4EC	Partnership for Every Child
PMP	Performance Management Plan
RFA	Request for Application
USAID	United States Agency for International Development

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ANNEX A: DCOF PERFORMANCE EVALUATION DESIGN MATRIX

CONCEPT NOTE

TASKING N003: PERFORMANCE EVALUATION DESIGN OF USAID/DCOF'S MOLDOVA AND BURUNDI PROJECTS

As part of the DRG Learning, Evaluation, and Research (DRG-LER) Activity, USAID has requested NORC to design and budget for a performance evaluation of USAID's Displaced Children and Orphans Fund (DCOF) projects in Moldova (Children in Moldova are Cared for in Safe and Secure Families), and Burundi (Family Care First: A Project to Ensure Children in Burundi are Placed in Protective and Permanent Family Care). DCOF's overall goal is to measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care. DCOF gives priority to projects that promise impact beyond direct services, which strengthen local capacity, and offer models and approaches for expansion, adaptation, and/or replication. While DCOF support in some cases is directed toward parents or other adults, the primary beneficiaries must be children younger than 18 years of age.

John Snow Research & Training Institute (JSI), acting on behalf of USAID and DCOF, issued a Request for Application (RFA) through the Advancing Partners and Communities Cooperative Agreement. Three applications were selected for awards of \$4.4M each to be implemented over 42-month periods. NORC will be evaluating two of the three awarded projects: Burundi, implemented by the International Rescue Committee (IRC), and Moldova, implemented by Partnership for Every Child (P4EC). The overall goals of these projects is to ensure children are in protective and permanent family care by reducing unnecessary separation of children from their families and by placing children who are outside of family care in nurturing families. The IRC-Burundi project will work with government and community-based stakeholders to ensure children under 18 years of age in Burundi are in protective and permanent family care, mainstream family-based child protection approaches at all levels of the government, and contribute to shifts in fundamental skills, social attitudes, and norms regarding child protection and welfare in 10 provinces. The P4EC-Moldova project will advance child care reform in Moldova, increasing the shift from institutional care to family-based care. The project will operate at national and local levels and will work intensively with 10 local authorities (LAs) in Moldova.

NORC's draft performance evaluation methodology and design are presented below. Since Burundi and Moldova are at different levels of development, and have in place different policies, systems and processes at the national and local level, this evaluation provides an important opportunity to understand specific factors that either contribute to, or do not affect, project objectives. The evaluation design presented here is based on information in the proposed program descriptions submitted by IRC and P4EC with their applications as well as initial phone conversations with both implementers. NORC may need to revise this performance evaluation design in consultation with USAID/DRG-LER and DCOF, and, project implementers once the programs starts in-country and more details are obtained. As discussed with USAID, this evaluation design is based on a set of assumptions about data that will be collected by the implementers and made available for the evaluation. Changes in the availability of this data will affect some evaluation design elements.

EVALUATION APPROACH

NORC's approach to performance evaluation entails a mix of mutually reinforcing qualitative and quantitative methods that reflect the program logic, research questions being addressed, and indicators. The qualitative analysis will provide local context and represent concrete examples that illustrate in greater detail the quantitative findings. Our approach to selecting the appropriate methodology is based on the USAID Evaluation Policy as well as our experience conducting evaluations in the field.

We also propose to conduct the DCOF evaluation in a participatory manner, not only in revising the evaluation design in consultation with USAID, DCOF, and the project implementers, but also in implementing the evaluation. Trips to the field will, therefore, involve engaging with the USAID mission in both Burundi and Moldova, implementers, project beneficiaries, and other stakeholders as needed through several phases of the evaluation including: identification of informants and questions for key informant interviews (KIIs), focus group discussions (FGDs), and survey questionnaires where needed; selecting appropriate data collection methods and analysis; and reaching consensus on findings, conclusions, and recommendations.

Given that Burundi and Moldova are at different levels of development, we understand activities and project focus will differ across the two countries, with different local and national institutions involved as counterparts and different intervention techniques being applied. Thus, the performance evaluation will take into consideration the local context and project implementation results by analyzing the achievement of targeted results, verifying implementer reports, considering the opinions and recommendations elicited during the IDIs and FGDs, and undertaking quantitative analysis of the results of secondary or primary surveys. We also have suggested several model-based approaches — multivariate statistical methods to objectively test whether the strength of correlations between project activities (as modulated by country-specific factors) and changes in outcome indicators support or reject the causal relations hypothesized. If they do, then the model provides estimates of the marginal effects of different intervention levels (e.g., intensity of training or number and type of grants) on outcomes of interest. More details on possible models we can analyze and their data requirements are discussed in the following section.

NORC's evaluation will be conducted using mixed methods. We will collect both quantitative and qualitative data and use model-based approaches to answer the main research questions outlined in the document provided by DCOF on January 8, 2014:¹

1. Have reintegration methods employed by the projects resulted in stable and sustained placements for children?
2. Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? Did the program impact beyond direct services?
3. Have prevention methods employed by the projects reduced risks of child/family separation?
4. Did the program bring out systemic changes at the community, regional, and national levels that are enabling children to live in family care and preventing inappropriate placements in institutional care?
5. By project end, to what extent have functioning structures been established that can continue to provide on an ongoing basis adequate case-management services for children at risk?

¹ These research questions were developed into a series of sub-questions that informed the proposed analysis and data requirements for the evaluation; see Annex A. The final list of indicators examined and reported by NORC will be included in the evaluation team's evaluation design report.

6. Did the project offer models and approaches for expansion, adaptation, and/or replication?

Children will be a key source of information for this evaluation in both Burundi and Moldova. As such, NORC will obtain their feedback as vital beneficiaries of the project, since perspectives of children differ from those of adults, particularly when their safety and well-being are the central issues. Information from children will be acquired through FGDs and direct observation while following child friendly research methodologies and necessary protocols outlined by NORC's Institutional Review Board (IRB). We may conduct KIs with 18 year olds living independently or on the street if possible.

There exist several cohorts of caregivers where children reside, and several age categories of children whose physical, nutritional and psychosocial characteristics can be evaluated. We will finalize the children age categories for the evaluation once we have a clearer understanding of the target beneficiary population for implementing partners. The caregiver (or living arrangement) cohorts targeted by the projects include²:

- Residential care / institutions³;
- Biological family for at risk/vulnerable children;
- Kinship care for at risk/vulnerable children.
- Perhaps street living for children who leave their families, but do not move into residential care and orphans in Burundi (this group will be finalized after further discussions regarding feasibility with the implementing partners)⁴.

Different age cohorts can be considered across the above categories based on who the implementers target: 0-3; 4-8; 9-11; 12-14; 15-17; and 18. Different data collection techniques will be used based on the age of the children, ensuring that they are appropriate for the child's development stage and following protocols in each country. For the younger cohort, direct observation and child-friendly participatory techniques such as cameras, games, and ranking activities will be employed; for the middle and oldest age cohorts, we will use interviews and FGDs, as suitable within each country and following NORC's IRB requirements.

NORC will develop panel data for this evaluation, following the same children (residential and at-risk) over time to measure change in their wellbeing and status. Please note that we are relying completely on the implementing partners (IPs) for data on children in residential care, and will work with the IPs in defining appropriate well-being indicators for residential and at-risk children which will be collected at two different points in time. However, we understand that a child that is successfully placed in permanent family care will have an open case file with data inputted by social workers for up to 12 months in Moldova and 6 months in Burundi. After this the child will "graduate" from the program and no longer be tracked. Therefore the endline data for successfully reintegrated children may not be collected at the end of the program if the child "graduates" before that time. NORC's current budget does not include returning to these "graduated" children at the end of the program to collect data.

Quantitative Evaluation Approach

Quantitative evaluations are dependent on adequate data availability to support quantitative analytic techniques that will provide results of sufficient statistical significance so as to be meaningful. Typically, this data is of two types, measures of treatment (who, what, where, when), and measures of outcome

² It is possible that some at risk children have previously been institutionalized, but we expect this to be a small sub-set.

³ The terms residential care and institutions are often used interchangeably. However, institution usually refers to large Soviet style buildings that house a large number of children; sometime 300 or more.

⁴ For children in residential care we plan to obtain FGD consent from the institutions since they are responsible for the child. For street children, we will discuss with the IPs from whom and how they think consent might be obtained and then propose this to our IRB. However, we cannot assume the IRB will approve it or that the conditions that the IRB might impose for approval would be ones that make it infeasible to proceed

(based on the research questions and taken at baseline and endline). Since implementers generally provide services directly to project beneficiaries, it is often times much more economical and efficient to have the implementers collect the data on treatment at the time of provision rather than have the evaluators shadow the process. A simple example would be registering the names, locations, and basic characteristics of beneficiaries the implementer trains. In addition, implementers will also be collecting outcome data such as the number of children reintegrated and their well-being. NORC will verify the quality of the implementer's data via a random selection of children reported as being reintegrated during the final evaluation, and the well-being of unified children as well as children in households where a high risk of separation is identified.

NORC's ability to utilize a model-based approach for this evaluation will be aided by the type and quality of data collected by the implementers. While NORC will do its own verification of project results shared by the implementer and data analysis, and conduct FGDs, KIIs, and undertake some primary data collection of project counterparts and beneficiaries, including children and caregivers, the evaluation will be greatly assisted if the implementers collect data that feeds into NORC's model-based approaches to evaluation questions. Our quantitative approach assumes that data as described in the logical frameworks in program descriptions of the implementers' applications will be made available to NORC and be sufficiently comprehensive to support model-based analysis. This quantitative data is expected to include:

- Administrative data from local institutions or government reports;
- National surveys conducted by the Governments of Burundi and Moldova;
- Surveys from assessments or evaluations by other donors, or IRC/P4EC;
- Program outputs and outcomes achieved in the logical framework of IRC/P4EC; and,
- School attendance and success data for reunited and at risk children.

NORC's primary data collection will be defined by what is required to fill in the gaps between data that will be obtained from the implementers and what is necessary to conduct the model-based analysis approved by DRG-LER, and to answer the evaluation questions and sub-questions. Based on the proposed implementer program description, NORC's primary data collection will likely include administrative data from members of the Community-Based Child Protection Communities or Centers for Family and Community Development in Burundi; and community-based social workers, or members of the gate-keeping commissions in Moldova as well as child welfare indicators and a survey of caregivers to supplement similar data being collected by the implementers.⁵ NORC will work closely with the implementing partners to determine a holistic measure of child well-being, specific to each country's context, and that can be easily measured, for example, (i) school attendance; (ii) how well the child is doing in school; (iii) how socially accepted and supported the child feels within the educational setting (by teachers and peers) and within the community and home; (iv) nutritional or physical indicators and (v) some psychosocial component of well-being.

NORC plans to conduct a survey of 500 caregivers each in Moldova and Burundi at baseline and endline. In both countries we plan to focus this survey on caregivers with at risk children including both biological and kinship families. In Burundi we will also try and include orphans living in group homes or street children who fend for themselves and are at risk of being placed in institutions. We will rely on the implementing partners to obtain information on children in institutional care due to difficulty in obtaining these records, their confidentiality, and in the case of Burundi, lack of child case files.

⁵ For example, the Moldova program description of P4EC describes a system of assessing and recording indicators of child wellbeing by the participating LAs. We assume this data will be a sufficient basis for creating a measure of child wellbeing in our planned model-based analysis. Once the specifics of this system are known, we can compare its components against existing tools for assessing child wellbeing (such as those developed by the USAID MEASURE Evaluation project).

Our conversation with P4EC revealed that they maintain detailed information on the family of children in institutional care, and plan to collect this information within the first 6 months of the project for all their target children who are currently in institutions (and whom they hope to reunite with families). IRC plans to collect and maintain information on children in institutional care on a rolling basis throughout the project years. Both organizations will share these data files with NORC and we will use it to evaluate the pre-post conditions in the family while the child is placed in institutions and after s/he has been reunited.

Model-based Analysis

Model-based approaches cover a broad – and therefore – rich array of specifications and are typically estimated using comprehensive information gathered at baseline and final evaluation through surveys, administrative records, and from data often made available by the service implementer. Examples of the approach include continuous-treatment-variable models and instrumental variables models. Under a model-based formulation, each observational unit (e.g., well-being of children in institutional care, or vulnerable children) contributes to our understanding of project results by allowing us to infer whether differences in the amount of program interventions can “explain” variation in (impacts on) performance once country-specific factors are taken into account.

Justification for Model Based Analysis

NORC’s literature review shows that model-based approaches on the results of the placement of children in institutional care are still very uncommon. The main problem is that most studies are based on very small sample sizes that allow only for the comparison of means between different types of placements. For example, Beckett & Thoburn (2002) compare placement outcomes for foster children along different dimensions, such as time spent in the institution and age at time of placement. Their sample size is low (220 observations), which apparently does not allow them to estimate multivariate models (though this is not discussed). Similarly, Judge (2014) looks at the record of 159 children placed into adoption and shows significant reductions in developmental delay (through a before-after comparison only).

One must keep in mind that a comparison of means is nothing other than a regression of the outcome of interest on an (binary) indicator variable for each group of interest. Our proposed approach would allow for the additional control of other factors that may act as confounding factors in this analysis. The prior approaches mentioned, by simply comparing different groups, risk picking the effect of other characteristics that partly determine placement and thereby lead to wrongly attributing their effect to the effect of placement. If DCOF elects to pursue a model based approach, NORC plans to greatly improve on the existing evidence by using larger samples than in the works cited above.

Multivariate estimations of the type we propose cover a category of standard techniques used in many different settings and much preferred to simple means comparisons when data allows (that is, when the sample size is large enough and other characteristics are observed). For example, in a related study Hiilamo (2008) uses a multivariate regression approach to explain the determinants of the increase in out of home placement for children in Finland over the 1990s and early 2000s. Given the larger number of anticipated beneficiaries in both countries, the opportunity to draw on such techniques is an enormous plus for the evaluation of the present DCOF Moldova and Burundi projects.

NORC proposes several different kinds of models, depending on the outcome variable of interest. Based on data availability in the two countries we have proposed model based approaches for evaluation questions 1 through 5. For Question 5, the outcome variables can be treated as being continuous, and a standard linear regression model is appropriate. Such models have their origin in the health statistics literature, but have been an essential part of the social sciences for a number of decades. They have been applied to topics as varied as time spent in unemployment, time until recovery from an illness, or the duration of peace treaties. The common theme among these applications is that the outcome of

interest is time elapsed before a certain event takes place, while in some cases this event may never materialize (in the present context, a child may never be re-institutionalized). We will estimate the effect of the factors of interest on the risk of re-institutionalization at different points in time.

For Questions 2, 3, and 4(a) we look at various outcomes that are binary in nature (i.e., either zero or one, occur or don't occur). For these cases, we will estimate standard models such as probit and logit that take the binary nature of the outcome explicitly into account.

Lastly, the outcome in Question 4(b) (number of institutional referrals) constitutes a count variable. The characteristic of such variables is that they only take a small number of different discrete, non-negative, values. Examples of count data include a woman's number of children, or a firm's number of patents. For the case at hand, we will be able to assess the effect of a number of program characteristics of interest on the number of expected institutional referrals.

In sum, to each of the five questions, there has not been much empirical work done at the level of rigor proposed by NORC. However, the techniques that NORC proposes to employ have an extensive track record and are supported by an immense literature across the social, health, occupational, education, political, and economic applied sciences. USAID clearly has an opportunity to fill this gap and apply well established techniques to an important application.

Model-based approaches and illustrative data requirements to answer the evaluation questions are shown in Table I, below. Further discussions with the implementing partners are required to determine which model is applicable and can be used in which country.

TABLE 1: MODEL-BASED APPROACHES AND DATA REQUIREMENTS

Data Requirements	Outcome (O), Treatment (T), Control (C) ⁶	Collected by Implementers	Possible Collection by Implementers	Collected by NORC
<p>Evaluation Question 1: Have reintegration methods employed by the projects resulted in stable and sustained placements for children?</p>				
<p>Evaluation Question 2: (a) Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? (b) Did the program impact beyond direct services?</p>				
<p>Possible Models:</p> <ul style="list-style-type: none"> ▪ For evaluation question 1 and question 2(a): Wellbeing of a reunified/vulnerable child as a function of where they have been placed (biological, extended, foster family, small group home if disabled child, remain in institution), existence of social service workforce to monitor the reunified children, if the household is participating in any saving or loans scheme, project-specific social protection schemes, success in school by reunified/vulnerable child. ▪ For 2(b): Indirect impact (enrollment or retention in school of reunited child (Burundi) and enrollment or retention in school for disabled reunited child (Moldova) / perception of untrained families that the child is better off at home) on an institutionalized/vulnerable child or reunited child as a function of a variable measuring likelihood that observational unit was treated (e.g., dichotomous variable as to whether parent received training or grant), gender, age, project location, financial resources of the government, existence of social welfare services/linkages to facilitate the integration, number of years the local authority/province has worked with donors, etc. 				
Number of children in institutional care in targeted locations	O	■		
Number of children in institutional care who are disabled	O	■		
Number of children in institutions (including those with disabilities) getting re-institutionalized after 3, 6, 9 and 12 months of being reunited with families or family based care	O		■	
Gender of institutionalized/vulnerable children	C	■		
Age of institutionalized/vulnerable children	C	■		
Age at placement of institutional/vulnerable children	C		■	
Social welfare budget of LA/province	C		■	
Presence of social welfare services/linkages	C, T	■		
Number of years the LA/province has received direct technical support from donor funded projects	T		■	
Wellbeing of a reunified/vulnerable child	O	■	■	■

⁶ T variables are those which are affected by the project and C variables are confounding factors that might influence outcomes but are outside of the control of the project.

Data Requirements	Outcome (O), Treatment (T), Control (C) ⁶	Collected by Implementers	Possible Collection by Implementers	Collected by NORC
Placement location of reunified/vulnerable child	C	■		
If household where the child is placed has received a VSLA grant (Burundi)	T		■	
If household where the child is placed has received any project specific social protection funds (Moldova and Burundi)	T		■	
Success in school by reunified/vulnerable/at risk children	C			■
Enrollment retention in school by reunited child	O			■
Perception of untrained families regarding child institutionalization	C			■
<p>Evaluation Question 3: Have prevention methods employed by the projects reduced risks of child/family separation?</p> <p>Possible Model:</p> <ul style="list-style-type: none"> Probability that an at-risk child < 18 is placed in institutional care as a function of the presence in the community of various social welfare services, presence of project-supported social protection schemes (cash transfers, grants), age of the at-risk child, urban/rural area, family size, gender of at-risk child, etc. 				
Number of at-risk children < 18 in targeted locations	C	■		
Presence and type of social welfare services	C, T	■		
Presence, type, and access to social protection schemes	T	■		
Age of at-risk children	C		■	
Gender of at-risk children	C		■	
Urban/rural location of at-risk children	C		■	
Family size of at-risk children	C		■	

Data Requirements	Outcome (O), Treatment (T), Control (C) ⁶	Collected by Implementers	Possible Collection by Implementers	Collected by NORC
<p>Evaluation Question 4: (a) Did the program bring out systemic changes at the community, regional, and national levels and (b) Are these systemic changes enabling children to live in family care and preventing inappropriate placements in institutional care?</p> <p>Possible Model:</p> <ul style="list-style-type: none"> For (a): [Separate measures of systemic change at community or regional level (Eg., existence/capacity of gatekeeping commission/community-based child protection communities/centers for family and community development, trained parent(s), number of social welfare schemes, existence of social service workforce, trained social service workforce, perception of parents and social workers about institutionalization)] as a function of [Degree of exposure or influence by a concrete project activity], given covariates of characteristics capturing variation in observational level of interest] For (b): Number of institutional referrals as a function of existence/capacity of gatekeeping commission/community-based child protection communities/centers for family and community development, trained parent(s), number of social welfare schemes, existence of social service workforce, trained social service workforce, perception of parents and social workers about institutionalization, parent participation in community group discussions, etc. 				
Institutionalization requests by parents to social workers	O		■	
Institutionalization referrals by social workers to gatekeeping commission/CPCs/CDFCs	O		■	
Number of gatekeeping mechanisms, community-based child protection communities/centers	C	■		
If parents of at-risk children have been trained	T	■		
Perception of parents and social workers regarding deinstitutionalization	O	■		
KAP scores of parents and social workers	T	■		
Parent participation in community group discussions	T	■		
<p>Evaluation Question 5: By project end to what extent has the project established functioning structures that can continue to provide on an ongoing basis adequate case management services for children at risk?</p> <p>Possible Model:</p> <ul style="list-style-type: none"> Local/provincial social welfare budget, level of education of social workers by community, years of service of social work (retention of social workers) as a function of community's exposure to or participation in project activities. Or Percent of required number of social workers (and perhaps of those exceeding a set level of training) per vulnerable child per community as a function of local/provincial social welfare budget, case load of social workers, level of education of social workers, length of service of social workers, existence of supervisory mechanisms, in-service training etc. 				
Education of social workers	C		■	
Number of social workers in targeted locations	C		■	
Age and gender of social workers	C		■	

Data Requirements	Outcome (O), Treatment (T), Control (C) ⁶	Collected by Implementers	Possible Collection by Implementers	Collected by NORC
Length of service of social workers			■	
Pre-service training of social workers	C,T		■	
In-service training of social workers (type and length)	T		■	

Qualitative Evaluation Approach

NORC’s quantitative evaluation will be supported by qualitative data collection, such as FGDs and KIs with key informants. The semi-structured open-ended interviews will be conducted with organizations and individuals as well as implementers, stakeholders and counterparts involved in different activities under the two projects. For the mid-term and end-line assessments, we will also review project reports and information pertaining to the two projects.

Qualitative approaches supplement and enrich quantitative analyses by investigating the reasons behind quantitative findings, and addressing aspects of research questions that are not well suited to quantitative analysis – for example, discussions with staff of residential institutions or gate keeping commissions to determine obstacles to reunifying children or retaining children at home respectively. The qualitative data collection will include the following:

- Desk-top review of materials related to the P4EC project in Moldova and the IRC Family Care First project in Burundi, as well as any material provided by USAID and DCOF;
- Interviews with USAID and DCOF officials in Washington DC, as well as with IRC and P4EC;
- Interviews with project implementation staff in Burundi and Moldova to discuss project implementation, results, and data burden;
- Interviews with other projects and interventions addressing similar child care issues to examine if the DCOF-funded projects appear to be complementing, duplicating, or in conflict with other efforts;
- In-depth, semi-structured interviews with selected program beneficiaries and stakeholders such as the Ministry of National Solidarity, Human Rights and Gender, Residential Care Centers, Village Savings and Loan Association (Burundi); and Ministry of Education, Social Assistance & Family Protection Directorate, Ministry of Labor, Social Protection & Family, etc. (Moldova);
- Site visits to some of the 10 provinces and local authorities where the project will be implemented in Burundi and Moldova respectively. These site visits will look at existing social service structures, social services, types of risks and vulnerabilities faced by children and families in the region, etc.;
- Direct observations – for example, of residential institutions – to cross-check information and identify additional issues. We will also observe a selection of households to examine the nature and quality of interaction between (i) family members and personnel facilitating reunification and reintegration of children, and (ii) reunited children and their caregivers;
- Five case studies in each country of children who are reunited with their families or placed in alternative family case by the project, but these reunifications fail. The case studies will include information obtained through KIs with the families, social worker, the child (if appropriate), and

P4EC/IRC. We will also review the case file and information from the gatekeeping institutions; and

- FGDs with program participants such as parents, foster caregivers, residential staff, children and other stakeholders. We have currently identified the following FGDs in the two countries; the number may change based on the child age cohorts targeted by the implementers in Burundi and Moldova respectively. These will be conducted at baseline, midline and endline.⁷

Moldova:

- 30 FGDs with children: (i) 3 categories of children x 2 age groups (12-14 and 15-17) = 6; chosen from 3 of the original 10 districts that have been getting technical assistance. Total = 18 FGDs. (ii) 3 categories of children x 2 age groups chosen from 2 of the 5 new targeted districts. Total = 12 FGDs.
- 11 additional FGDs:
 - NGOs (1)
 - Social workers (2)
 - Residential care staff (2)
 - Gate keeping commissions (1)
 - Parent of children in institutional care (2)
 - Teachers (1)
 - Community leaders: religious or leaders (2)

Burundi:

- 18 FGDs with children: 3 categories of children x 2 age groups (12-14 and 15-17) x 3 of the 10 target provinces.
- 13 additional FGDs.
 - NGOs (1)
 - Social workers (3)
 - Residential care staff (3)
 - Staff of Child Protection Committees (1)
 - Staff of Center for Family and Community Development (1)
 - Parents of children in institutional care (2)
 - Community leaders (teachers, religious or government leaders) (2)

Data Collection

NORC identified and reviewed the credentials and experience of several local research entities in Burundi and Moldova with experience conducting surveys and qualitative data collection. Key factors in creating a short list of candidates for our local partner included: experience carrying out social scientific surveys and qualitative research; adherence to international and national human subjects protections; references confirming timeliness and quality of quantitative and qualitative data products; and demonstrated cultural competence for carrying out qualitative and quantitative data collection on sensitive subjects among diverse populations (including rural and urban populations, vulnerable families and youth, social workers, and institution staff). After examining both technical and cost considerations,

⁷ We will also explore conducting a slightly fewer number of FGDs with children (while still keeping this number large) and instead do a few FGDs with community members such as teachers, religious and political leaders, and parents to explore attitudes towards institutionalization. Thus while the total number of FGDs will remain the same, the targeted participants may change slightly.

we have made a preliminary selection of working with IMAS in Moldova and CARD Engineering in Burundi.

NORC will fully supervise and support the work of the local data collection firm, training data gatherers in using the instruments developed for the evaluation, and supervising and guiding the data collection and cleaning. All data analysis will be conducted by NORC.

EVALUATION LIMITATIONS

There are several limitations inherent to the design of this evaluation:

- **Unforeseen Circumstances Changing Project Components:** There may be unforeseen circumstances over the evaluation period that can lead the implementer or USAID/DCOF to want to modify the roll-out, mix, or even nature of the project components. These types of changes pose the risk of compromising the evaluation design and thus, the implementer and evaluator must collaborate closely on how to address such threats over the evaluation period.
- **Data Availability:** While the implementers and evaluation team can collect and generate primary data, it may be difficult to obtain quality administrative records which will affect some model-based specifications.
- **Selection Bias:** As some key informants may decline to be interviewed, there is a possibility of *selection bias*, i.e. those respondents who choose to be interviewed might differ from those who do not in terms of their attitudes and perceptions, affiliation with government/non-government structures, and socio-demographic characteristics and experience.
- **Recall Bias:** Since a number of questions raised during the interviews will deal with issues that took place in the past, *recall bias* may affect their response.
- **Halo Bias:** There is a known tendency among respondents to under-report socially undesirable answers and alter their responses to approximate what they perceive as the social norm (*halo bias*). The extent to which respondents will be prepared to reveal their true opinions may also vary for some questions that call upon the respondents to assess the attitudes and perceptions of their colleagues or people on whom they depend upon for the provision of services. To mitigate this limitation, NORC will ensure confidentiality and anonymity guarantees, to in-depth interview, focus group and survey respondents; and conduct the interviews in a neutral setting where respondents feel comfortable.

EVALUATION TIMELINE AND DELIVERABLES

Months 1-3

Shortly after Tasking approval, and prior to the first trip for the baseline, NORC will organize a brainstorming meeting, to develop evaluation materials such as evaluation guides, protocols, and tools. A similar meeting of all team members will occur again right before the mid-term and final evaluation.

During this period we will also have further consultations with P4EC and IRC to: (1) Understand more fully how each implementer plans to carry out their project, particularly with respect to the timing of project activities, their geographic location, and the identity of key partners and stakeholders; and (2) discuss with the implementers what data they will be collecting under the M&E components of their projects and reach consensus between NORC, USAID, and the implementers on which parties will collect which data. We assume these two tasks can occur concurrently with the development of the implementers' work plans during the first 8-12 weeks of the project and can be done without need for travel to the field. These two tasks need to be completed before the evaluation design can be completely finalized.

Deliverable: Evaluation design report.

Months 3-6

A trip by evaluation team members will occur to launch the baseline data collection with the aim of completing data collection field work by the end of month 6. Ideally, we propose establishing the baseline prior to the start of project activities. However, in initial conversations with P4EC and IRC, NORC learned that P4EC will obtain information on children currently in institutional care in target LA's over the first 6 months of the project; and IRC will collect this information on a rolling basis across all project years. NORC's baseline evaluation will therefore be based on report reviews, KIIs, a survey of caregivers of at risk children, and FGDs with organizations listed above under qualitative data collection. We may not be able to have the desired number of FGDs with children in institutions (we will with at risk children) since both implementing partners have stressed the need to contact and establish relationships with the institutions before we engage with them as evaluators.

We will also work with the implementing partners (IPs) to define a wellbeing indicator for institutional and at risk children, taking into account the country context. Both IPs have committed to measuring the wellbeing indicator at two points in time: at first contact with the child and later after reuniting children in institutional care; and working with the community to safeguard and strengthen families with at risk children.

Months 7-9

Analysis of the baseline data will take place in the following quarter.

Deliverable: Baseline report, data collection instruments, and data files.

Mid-term and Final Reports

We propose to conduct the mid-term review 18-21 months after project implementation begins and to conduct the final evaluation during the period 37-42 months after project implementation begins.

Deliverables: Mid-term report, data collection instruments, and data files (month 21); final report and presentation, data collection instruments, and data files (month 42).

PROPOSED STAFFING

NORC has selected an exceptionally qualified team to conduct the performance evaluation of the two DCOF projects. Our approach is to partner a subject area expert with NORC evaluation experts well versed in the different methodologies outlined above.

The team members will work in close coordination throughout the evaluation, with Kelley Bunkers serving as the lead subject area expert and Dr. Ritu Nayyar-Stone as the lead Evaluation expert. NORC's Evaluation Team will receive expert advice on model-based approaches during the design and evaluation implementation from the DRG-LER Research Director, Dr. Clifford Zinnes; however, NORC's principal interlocutor with USAID/DCOF for this evaluation will be Dr. Ritu Nayyar-Stone. The Moldova team will be comprised of Kelley Bunkers and Ritu Nayyar-Stone; the Burundi team will be comprised of Sian Long and Mawadda Damon. These experts are described briefly below and presented more fully in their resumes in Annex B. Prior to country visits, the team will work closely in developing the evaluation tools⁸ for this evaluation.

NORC will work with a local data collection firm in both countries and will seek to hire a local coordinator in each country who will assist the team by arranging appointments during their scoping trip, providing administrative and logistical support during their visits to the field, and following up on

⁸ Semi-structured KIIs guides, FGD guide and protocol, survey questionnaires, and case study template.

outstanding issues after the Evaluation Team leaves. The local coordinators will also provide some technical support in the sense of working closely with P4EC and IRC to keep us updated on implementation of the project as it may affect our evaluation design, collecting secondary data from in-country sources, and doing some primary data collection for the case studies mentioned in the qualitative data collection section, with the case study data collection tools developed by the NORC team.

While in country, the technical specialists (Kelley and Sian) will be conduct KIIs with the implementers, government officials, gatekeeping institutions, and social workers and complete direct observations of at-risk, residential care, and reintegrated children. They will assist the evaluators (Ritu and Mawadda) in the training of the local data collection firm enumerators, focus group facilitators, and observers, focusing on issues related to data collection protocols with vulnerable children.

While in country, the evaluators (Ritu and Mawadda) will focus mainly on training the local data collection firm and the local coordinator in best practices of survey administration and focus group moderation in addition to training on the purpose of the data collection and the data collection instruments themselves. Training will last a few days and include role playing by the field staff. The evaluators will observe the survey pilot and pilot focus groups and work with the team (technical specialists and local data collection firm) to adjust instruments for the main field data collection. They will train the local coordinator to continue oversight of the local data collection firm. They will also join the technical experts on a portion of the KIIs, particularly those with the implementers in order to better understand the program, and will assist with other KIIs once the data collection trainings and pilots are completed.

Kelley Bunkers, Social Welfare and Child Protection Expert (Moldova), has more than twenty years of experience working with U.S. and foreign governments, diplomatic missions, UNICEF, international organizations and private foundations related to social welfare, child protection, and child care reform issues. Ms. Bunkers' experience in Moldova began on an assignment for UNICEF in 2000. During this consultancy, she helped the Government of Moldova and its National Agency for the Protection of Child Rights to develop the "End of Decade Review Report" which was based on the 1990 World Summit for Children. Her child care experience in Moldova since then has expanded her role as it relates to the welfare of children in the country. Since 2012, Ms. Bunkers has been involved in a UNICEF-funded evaluation to determine the progress of de-institutionalization efforts of the national foster care system. In this capacity, she provides insight and suggestions for how changes in policy framework, public awareness, and programming support can result in an expanded number of caregivers and increased access for both children with disabilities and those under the age of three. Ms. Bunkers has worked on projects in Latin America, East Africa, and Eastern Europe, and has published work that demonstrate her expertise as it relates to vulnerable children and families, foster care, alternate care, adoption, child protection, de-institutionalization. She also has experience collecting information through qualitative evaluation methodologies such as key informant interviews and focus group discussions. Ms. Bunkers holds an M.A. in Advanced Studies in Children's Rights from the University of Fribourg, and a B.A. in Psychology from the University of Oregon. She is a native English speaker, has advanced professional proficiency in Romanian, and is fluent in Spanish.

Mawadda Damon, Performance Evaluator (Burundi), is a Principal Research Analyst at NORC at the University of Chicago's International Projects division. Ms. Damon has five years of experience in the design, management, and implementation of impact, performance, and implementation evaluations. Her experience includes the development of results frameworks and indicators; the design of in-depth interview and focus group guides and survey instruments; training of interviewers; descriptive analyses of quantitative survey data; the use of NVivo software to organize, code, and analyze large amounts of qualitative data; and report writing. Ms. Damon's experience in evaluation includes leading focus groups with farmers and conducting key informant interviews for a food security project in Burkina Faso and

leading a three-year implementation evaluation of an olive sector project in Morocco where she worked exclusively in French to design the methodology of the evaluation; develop the data collection instruments for farmers, farmer organization leaders, and olive press owners; train interviewers; conduct key informant interviews in the field; analyze both the qualitative and quantitative data; and write reports. Ms. Damon has also managed and supported data collection for a series of impact evaluations using a range of randomized-control trial, quasi-experimental, and pre-post designs. She has four years of experience working on evaluations of projects that aim to improve local and/or national public programs in a broad range of countries in Sub-Saharan Africa (Burkina Faso, Ghana, Uganda, and Rwanda), Asia, and Latin America. Ms. Damon holds a Master in Public Policy from the Harvard Kennedy School of Government. She is fluent in English, French, Arabic, and Turkish.

Siân Long, Children's Rights and Child Protection Expert (Burundi), is an independent consultant working on child protection, children affected by HIV and child rights. She has over twenty years of policy and programming experience in vulnerable children's issues, especially in the context of HIV. She has extensive expertise in policy and strategy development for vulnerable children and translation of policy into practical programming approaches. In the past three years she has been directly involved in practical issues on reintegration, including currently supporting Family for Every Child on a study on reintegration of children from residential care in Malawi, translating qualitative research findings into a set of practical recommendations for reintegration and improved gatekeeping. She is also currently working with a team from Maestral on the development of a practical alternative care framework for Liberia, including development of assessment tools, development of draft alternative care guidelines and supporting a team of government and civil society stakeholders to develop an action plan for alternative care. Much of this focuses on non-institutional alternatives and promotion of family-based options. Recent support to national government in Swaziland and Lesotho on the mapping and assessment of their child protection systems involves a focus on child care reform, which currently involves support for the development of a first national child protection strategy and action plan in Lesotho, with a focus on moving from institutional to foster and other community-based care options. Her policy and strategy work is linked to practical experience with community-based child-focused programming on the ground, primarily through a range of OVC jobs and consulting positions since 2000, as a result of which she has familiarity with district to community-level mechanisms for supporting children in 'family-based care' and linking this care to the formal system. Ms. Long holds an M.Ed. in Education for Primary Health from the University of Manchester, UK and a B.A. in social and Political Science from the University of Cambridge. Ms. Long is a native English speaker and has working proficiency in French. She was based in South Africa for 11 years from 2000-2011 and in Mozambique prior to that.

Ritu Nayyar-Stone, Performance Evaluator (Moldova), is an economist and a Senior Research Scientist at NORC at the University of Chicago's International Programs Center with over twenty years of experience focusing on service delivery and public management issues in Asia, Africa, Central and Eastern Europe, the Russian Federation and Central America. Dr. Nayyar-Stone has trained World Bank and Inter-American Development Bank staff on outcome monitoring to help staff identify practical methods to improve identification of outcomes and outcome indicators for policy decision-making and monitoring, and, data collection techniques leading to improved specification and tracking of project impact. She has advised the government of Cambodia on the design of a National Monitoring and Evaluation Framework to measure the impact of decentralization on service delivery, reduction of poverty and governance; and was team leader for a project assisting the Ministry of Local Development, Government of Egypt develop a blueprint and indicators for a local development observatory to measure the impact of decentralization on services and local development. She has analyzed and written reports on several household surveys in Georgia, Pakistan, Rwanda, and Albania, examining citizen's views on local government and service delivery which are converted into indicators and tracked to make budget allocation and policy decisions. Dr. Nayyar-Stone was part of a team updating and

customizing USAID's 5-day Introduction to Managing for Results course for headquarter and mission staff worldwide. She also contributed a new chapter for this course on "Managing for Development Results: Building Local Capacity", based on the Paris Declaration on Aid Effectiveness.

Dr. Nayar-Stone has conducted numerous assessments and evaluations. Most recently she was the evaluator for two USAID funded projects in Georgia: Judicial Improvement and Legal Empowerment Project and Advancing National Integration where she helped design and analyze surveys and focus group discussions with key beneficiaries of these project. Her work on ANI involved obtaining information from and analyzing data from youth aged 15-18. She is also assisting with the evaluation of interventions that seeks to foster systemic and sustainable change in agricultural markets in Kenya, using both experimental and quasi-experimental designs. Dr. Nayar-Stone holds a Ph.D. in Economics and Public Finance, and an M.A. in Economics from Boston University, an M.A. in Economics from Bombay University, India, and a B.A. in Economics from St. Xavier's College, Bombay University, India.

Clifford Zinnes, Research Director and Advisor, is a Senior Fellow the NORC at the University of Chicago's International Projects Department, specializes in the application of quantitative methods and institutional economics in impact evaluations to improve aid effectiveness and institutional and economic performance in developing and transitional economies. Of his 35 years of policy research and implementation experience, he has dedicated the last dozen years to designing and overseeing all aspects of impact evaluation – both experimental and quasi-experimental randomized evaluations – across a wide range of sectors, including public sector transparency and governance initiatives, training programs, property rights regulation, land purchase financing, voluntary resettlement activities, agricultural support services and irrigation, water and sanitation, children's nutrition, pollution abatement, wildlife conservation, and forest land restitution for AusAid, CIDA, DfID, IFC, MCC, FAO, USAID, USDA, UNDP, UNIDO, World Bank, Soros Open Society, and the Bill and Melinda Gates Foundation. Among the over twenty countries on four continents in which he has conducted field work, his most recent impact evaluations include Cape Verde (irrigation and bridges), Colombia (new agency to increase local-government transparency), Ecuador (value-chain strengthening in narco-infested border regions), Egypt (public disclosure of pollution abatement performance), Lesotho (water and sanitation; rural health centers), Namibia (governance strengthening of indigenous-plant harvester collectives and of wildlife conservancies), and Zambia (water pumps and farmer-group formation).

Dr. Zinnes is an expert on incentive-based institutional arrangements to promote more accountable local government; recently he developed race-to-the-top "tournaments" for local governments in Morocco (budget reform) and in Egypt (environmental compliance). The Brookings Institution has recently published his book on the subject, *Tournament Approaches to Public Policy in Developing Countries*. In Colombia for NED and IRI, he designed and directed two impact evaluations of a *Salón de transparencia* and a one-stop shop in Cartagena. Each comprised separate randomized experiments at the household and agency level. This study was one of the first quasi-experiments applied in field of democracy and governance. He is currently directing an impact evaluation of a capacity strengthening program being implemented by Results for Development under Hewlett Foundation funding of independent budget monitoring organizations in Rwanda, Uganda, and Ghana. In addition to impact evaluations, he has worked on institutional and policy reform across a number of areas: white papers for USAID on fragile states and for the IFC on the informal sector's influence on the business enabling environment; privatization in the Former Soviet Union and Central and Eastern Europe; the International Tax Program at Harvard Law School (VAT, income, and trade tax reforms in Belize, Dominican Republic, The Gambia); environmental tax reforms in Romania and Thailand; Mongolia's "shadow economy" (developing statistical protocols for sensitive questions). He has published widely on all the above topics.

Dr. Zinnes has served on the faculty of Harvard University and the University of Maryland, as well as taught at several universities abroad. He holds a Masters in Econometrics and a PhD in International

Economics from the University of Pennsylvania. He is a native English speaker, has advanced professional proficiency in Romanian and Spanish, and working proficiency in French.

**ANNEX A (AS PART OF THE CONCEPT NOTE):
DCOF PERFORMANCE EVALUATION DESIGN MATRIX**

TABLE AI: DCOF PERFORMANCE EVALUATION DESIGN MATRIX

Evaluation Questions and Sub-Questions	Data Source	Methodology	Data Analysis
Evaluation Question 1: Have reintegration methods employed by the projects resulted in stable and sustained placements for children?			
<p>(a) During the tracing process, what percentage of children in residential care have been identified a family based option that is safe and appropriate?</p> <p>(b) Are increased number of children living in residential institutions being placed in family based care (disaggregated by biological, extended and foster families)?</p> <p>(c) Is the wellbeing of reunified and placed children assessed as being adequate?</p>	<ul style="list-style-type: none"> ▪ Project work plans, quarterly report, PMP ▪ Project technical documents ▪ Government legislation and relevant documents of specific ministries ▪ Data on institutional children collected by the IPs ▪ Bi-annual sociological survey (Moldova) ▪ Administrative records ▪ Inter-Agency Child Protection Information Management System (CPIMS) data (Burundi) ▪ 	<ul style="list-style-type: none"> ▪ Document review ▪ In-depth interviews ▪ Focus group discussions with staff of residential institutions, social welfare staff etc. ▪ Independent analysis of the demand for and obstacles to reunification ▪ Independent analysis of the supply of alternate family care and child wellbeing ▪ On-site observations 	<ul style="list-style-type: none"> ▪ Analysis of targeted project outputs, and outcomes ▪ Verification of project reporting ▪ Perceptions and feedback from KII and FGDs ▪ Quantitative analysis of surveys ▪ Synthesis and triangulation of qualitative and quantitative data ▪ Chi-square tests of significance between wellbeing of reunified child and where they have been placed after reunification
Evaluation Question 2: (a) Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? (b) Did the program impact beyond direct services?			
<p>(a) Did the project provide a core package of services to help ensure that institutional care is prevented when possible and that reunified children and at risk children remain in family care?</p> <p>(b) Are increased number of disabled children reintegrated from institutions to either biological families or alternative family care? (Moldova)</p> <p>(c) Has the government capacity to provide oversight on the standard of care in existing residential care</p>	<ul style="list-style-type: none"> ▪ Project work plans, quarterly report, PMP ▪ Administrative records ▪ Project technical documents ▪ Government legislation and relevant documents of specific ministries ▪ ▪ Bi-annual sociological survey (Moldova) ▪ Inter-Agency Child Protection Information Management System (CPIMS) data (Burundi) ▪ Survey of caregivers of at risk children 	<ul style="list-style-type: none"> ▪ Document review ▪ In-depth interviews ▪ Focus group discussions with staff of small group homes with disabled children, social welfare staff etc. ▪ Independent analysis of the demand for and obstacles to reunification of vulnerable children ▪ Independent analysis of the supply of alternate family care and wellbeing of vulnerable children ▪ On-site observations of small group home for vulnerable children 	<ul style="list-style-type: none"> ▪ Analysis of targeted project outputs, and outcomes ▪ Verification of project reporting ▪ Perceptions and feedback from KII and FGDs ▪ Quantitative analysis of surveys ▪ Synthesis and triangulation of qualitative and quantitative data ▪ Chi-square tests of significance of wellbeing of disabled children and where they have been placed after reunification

Evaluation Questions and Sub-Questions	Data Source	Methodology	Data Analysis
<p>centers improved? (Burundi)</p> <p>(d) Have there been other unanticipated positive or negative results of the program?</p>			
<p>Model-Based Approach for Evaluation Question 1 and 2</p> <ul style="list-style-type: none"> ▪ For evaluation question 1 and 2(a): Wellbeing of a reunified/vulnerable child as a function of where they have been placed (biological, extended, foster family, small group home if disabled child, remain in institution), existence of social service workforce to monitor the reunified children, if the household has received any VSLA grant (Burundi), project-specific social protection schemes, success in school by reunified/vulnerable child. ▪ For 2(b): Indirect impact (enrollment retention in school of reunited child (Burundi) and enrollment or retention in school for disabled reunited child (Moldova) / perception of untrained families that the child is better off retained) on an institutional/vulnerable child or reunited child as a function of a variable measuring likelihood that observational unit was treated (e.g., dichotomous variable as to whether parent received training or grant), gender, age, project location, financial resources of the government, existence of social welfare services/linkages to facilitate the integration, number of years the local authority/province has worked with donors, etc. 			
<p>Evaluation Question 3: Have prevention methods employed by the projects reduced risks of child/family separation?</p>			
<p>(a) Are households with children at risk of family separation stabilized and strengthened?</p> <p>(b) Are children at risk of losing family care continuing to live with appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?</p>	<ul style="list-style-type: none"> ▪ Project work plans, quarterly report, PMP ▪ Project technical documents ▪ Bi-annual sociological survey (Moldova) ▪ Inter-Agency Child Protection Information Management System (CPIMS) data (Burundi) ▪ Survey of caregivers of at risk children 	<ul style="list-style-type: none"> ▪ Document review ▪ Administrative records ▪ In-depth interviews with local/provincial authorities ▪ Perception of caregivers of at risk children regarding institutionalization ▪ Independent analysis of support provided to families with at-risk children ▪ Independent analysis of national policies and local capabilities 	<ul style="list-style-type: none"> ▪ Analysis of targeted project outputs, and outcomes ▪ Verification of project reporting ▪ Perceptions and feedback from KII and FGDs ▪ Quantitative analysis of surveys ▪ Synthesis and triangulation of qualitative and quantitative data
<p>Model-Based Approach for Evaluation Question 3</p> <ul style="list-style-type: none"> ▪ Probability that an at-risk child < 18 is placed in an institution as a function of the presence in the community of various social welfare services, presence of project-supported social protection schemes (cash transfers, grants), age of the at-risk child, urban/rural area, family size, gender of at-risk child, etc. 			

Evaluation Questions and Sub-Questions	Data Source	Methodology	Data Analysis
Evaluation Question 4: (a) Did the program bring out systemic changes at the community, regional, and national levels that are enabling children to live in family care and (b) preventing inappropriate placements in institutional care?			
<p>(a) Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote family care for children without parental care?</p> <p>(b) Is there an improvement in caregivers' parenting skills and practices?</p> <p>(c) Is there any change in attitude towards institutional care among parents and community members?</p>	<ul style="list-style-type: none"> ▪ Project work plans, quarterly report, PMP ▪ Administrative records ▪ Project technical documents ▪ Government legislation and relevant documents of specific ministries ▪ Relevant report of project partners and beneficiaries ▪ Bi-annual sociological survey (Moldova) ▪ Inter-Agency Child Protection Information Management System (CPIMS) data (Burundi) ▪ Survey of caregivers of at risk children 	<ul style="list-style-type: none"> ▪ Administrative records ▪ KIIs ▪ FGD with Gatekeeping Commissions (Moldova) and equivalent entity in Burundi ▪ Independent analysis of changes in community, regional and national level due to the program 	<ul style="list-style-type: none"> ▪ Analysis of targeted project outputs, and outcomes ▪ Verification of project reporting ▪ Perceptions and feedback from KII and FGDs ▪ Quantitative analysis of surveys ▪ Synthesis and triangulation of qualitative and quantitative data ▪ Results of pre and post-test or baseline and end-line survey to determine change in attitudes or perceptions after training or an education campaign.
Model-Based Approach for Evaluation Question 4			
<ul style="list-style-type: none"> ▪ For (a): [<u>Separate measures of systemic change at community or regional level</u> (Eg., existence/capacity of gatekeeping commission/community-based child protection communities/centers for family and community development, trained parent(s), number of social welfare schemes, existence of social service workforce, trained social service workforce, perception of parents and social workers about institutionalization)] as a function of [<u>Degree of exposure or influence by a concrete project activity</u>], given covariates of characteristics capturing variation in observational level of interest] ▪ For (b): Number of institutional referrals as a function of existence/capacity of gatekeeping commission/community-based child protection committees/centers for family and community development, trained parent(s), number of social welfare schemes, existence of social service workforce, trained social service workforce, perception of parents and social workers about institutionalization, parent participation in community group discussions, etc. 			
Evaluation Question 5: By project end to what extent have functioning structures, workforce and services been established that can continue to provide on an ongoing basis adequate case management services for children at risk?			
<p>(a) Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect</p>	<ul style="list-style-type: none"> ▪ Project work plans, quarterly report, PMP ▪ Administrative records ▪ Project technical documents ▪ Government legislation and relevant documents of specific ministries 	<ul style="list-style-type: none"> ▪ Administrative records ▪ KIIs ▪ FGD with Gatekeeping Commissions (Moldova) and equivalent entity in Burundi ▪ Independent analysis of changes in community, 	<ul style="list-style-type: none"> ▪ Results of KAP surveys ▪ Analysis of targeted project outputs, and outcomes ▪ Verification of project reporting

Evaluation Questions and Sub-Questions	Data Source	Methodology	Data Analysis
<p>children at the local level?</p> <p>(b) Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?</p>	<ul style="list-style-type: none"> ▪ Bi-annual sociological survey (Moldova) ▪ 	<p>and family capacity and skills to protect children</p>	<ul style="list-style-type: none"> ▪ Perceptions and feedback from KII and FGDs ▪ Synthesis and triangulation of qualitative and quantitative data
<p>Model-Based Approach for Evaluation Question 5</p> <ul style="list-style-type: none"> ▪ Local/provincial social welfare budget, level of education of social workers by community, years of service of social work (retention of social workers) as a function of community's exposure to or participation in project activities. Or ▪ Percent of required number of social workers (and perhaps of those exceeding a set level of training) per vulnerable child per community as a function of local/provincial social welfare budget, case load of social workers, level of education of social workers, length of service of social workers, existence of supervisory mechanisms, in-service training etc. 			
<p>Evaluation Question 6: Did the project offer models and approaches for expansion, adaptation, and/or replication?</p>			
<p>(a) Were lessons learned widely discussed and disseminated during project implementation?</p> <p>(b) Were any best practices or successful techniques institutionalized?</p>	<ul style="list-style-type: none"> ▪ Project work plans, quarterly report, PMP ▪ Project technical documents ▪ Government legislation and relevant documents of specific ministries ▪ Relevant report of project partners and beneficiaries ▪ Mini surveys of partners and beneficiaries 	<ul style="list-style-type: none"> ▪ Document review ▪ KIIs ▪ Independent analysis of extent of dissemination and institutionalization of best practices 	<ul style="list-style-type: none"> ▪ Analysis of targeted project outputs, and outcomes ▪ Verification of project reporting ▪ Perceptions and feedback from KII and FGDs ▪ Synthesis and triangulation of qualitative and quantitative data

ANNEX II: EVALUATION QUESTIONS AND INDICATORS

Exhibit I: Evaluations Questions and Indicators

Indicator	Indicator Computation Variables
<p>Evaluation Question 1: Have reintegration methods employed by the projects resulted in stable and sustained family-based placements for children? [focus is on 5 "new" LAs only]</p>	
<p>(a) Are increased number of children living in residential care facilities being placed in family care?</p>	<ul style="list-style-type: none"> ▪ % of targeted children in residential care placed in permanent family care, disaggregated by type of care and disabled/orphan children ▪ # of targeted children in residential care ▪ # of targeted children in residential care placed with biological families ▪ # of targeted children in residential care placed with safe and stable alternative family-based care (disaggregated by category)
<p>(b) During the tracing process, what percentage of children in residential care have been <u>identified</u> a birth family or kinship care option that is safe and appropriate?</p>	<ul style="list-style-type: none"> ▪ % of targeted children in residential care out of all targeted children in residential care <u>identified</u> a birth family or kinship care option, (disaggregated by <u>type of care</u> and <u>CWD/special needs children</u>) ▪ % of targeted children in residential care out of the total # of children in targeted residential care facilities (disaggregated by <u>type of care</u> and <u>CWD/special needs children</u>) ▪ # of targeted children in residential care ▪ Total # of children in targeted residential care facilities ▪ # of targeted children in residential care that have birth family identified for placement (disaggregated by CWD/special needs children and non-CWD/special needs children) ▪ # of targeted children in residential care identified a kinship care option (disaggregated by CWD/special needs children and non-CWD/special needs children)
<p>(c) What factors prevented placement of children in residential care into permanent family care?</p>	<ul style="list-style-type: none"> ▪ Availability of family care options ▪ Obstacles to deinstitutionalization ▪ Children's level of desire for reunification or deinstitutionalization ▪ Process used to identify placement
<p>(d) What type of social service follow-up is provided to deinstitutionalized children, by whom and for how long?</p>	<ul style="list-style-type: none"> ▪ Opinions on the adequacy of social service follow-up ▪ List of different types of social services provided as part of follow-up of reunited and deinstitutionalized children; who provides them, and typically for how long
<p>Evaluation Question 2: (a) Did the program measurably improve the safety, well-being, and development of highly vulnerable children, particularly those who are living without adequate family care? (b) Did the program impact beyond direct beneficiaries?</p>	
<p>(a) Did the project provide a core package of services to help ensure that residential care is prevented when possible</p>	<ul style="list-style-type: none"> ▪ % of targeted children that received core package of services, by type of service ▪ % of targeted children in at-risk families that remain in family care ▪ # of targeted children that received core package of services, by type of service ▪ Total # of targeted children in at-risk families

Indicator		Indicator Computation Variables
<p>and that reunified and deinstitutionalized children and at-risk children remain in family care?</p> <p>A core package of services includes: family support service (including financial support); means-tested cash benefit (as a social protection measure); alternative care services, mainly foster care, psycho-social support in school in order to meet the child's individual educational needs.</p>	<ul style="list-style-type: none"> ▪ % of targeted children in residential care who experience a ruptured placement ▪ Reasons for ruptured placement ▪ Was the relevant core package of services provided to achieve the objectives? 	<ul style="list-style-type: none"> ▪ # of children in targeted at-risk families that remain in family care ▪ # of children in targeted at-risk families that are that required out-of-home placement ▪ (# of residential care children placed in permanent family care, measured above) ▪ # of ruptured placements of deinstitutionalized children ▪ Selection criteria of at-risk families
(b) Are there fewer children living in residential care facilities?	<ul style="list-style-type: none"> ▪ Total # of children in residential care facilities in program-targeted areas ▪ # of children admitted to residential care facilities in program-targeted areas 	
(b) Is the wellbeing of deinstitutionalized children assessed as being adequate?	<ul style="list-style-type: none"> ▪ See separate wellbeing indicator document ▪ Perspective of social workers and teachers of deinstitutionalized children's wellbeing ▪ Opinions of children on their wellbeing ▪ Opinions of caregivers on children's wellbeing. 	
(c) Have there been other unanticipated positive or negative results of the program?	<ul style="list-style-type: none"> ▪ Unanticipated outcomes that emerge from qualitative inquiry from among direct beneficiaries ▪ Perceived impact among indirect beneficiaries 	
Evaluation Question 3: Have prevention methods employed by the projects reduced risks of child/family separation?		
(a) Are households with children at risk of family separation stabilized and strengthened?	<ul style="list-style-type: none"> ▪ (% of targeted children in at-risk families that remain in family care, measured above) ▪ Wellbeing of targeted children in at-risk families (see wellbeing indicator) ▪ Opinions on support services received by families 	
(b) Were the relevant families chosen for inclusion in the project?	<ul style="list-style-type: none"> ▪ Criteria used for selection of families with children at-risk of separation 	
(c) Are children at risk of losing family care continuing to live in	<ul style="list-style-type: none"> ▪ Quality of changes in national policies ▪ # of child welfare staff at national and local levels 	

Indicator		Indicator Computation Variables
appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?	<ul style="list-style-type: none"> ▪ Average number of active case load per social worker in target locations ▪ Retention rates of child welfare staff ▪ Training inputs and training curriculum 	
Evaluation Question 4: (a) Did the program bring out systemic changes at the community, regional, and national levels that are enabling children to live in family care and (b) preventing inappropriate placements in institutional care?		
(a) Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote appropriate family care for children without parental care?	<ul style="list-style-type: none"> ▪ Knowledge of national policies by gov. authorities, state, and non-state service providers, community members, and parents ▪ Support for national policies by gov. authorities, state, and non-state service providers, community members, and parents 	
(b) Is there an improvement in caregivers' parenting skills and practices?	<ul style="list-style-type: none"> ▪ Quality of caregiver parenting skills and practices ▪ % of parents/kinship caregivers with improved parental skills 	<ul style="list-style-type: none"> ▪ Total # of caregivers targeted by the project to improve their parenting skills ▪ #of caregivers with improved parental skills ▪ Change in parenting assessment (doing tests of families on parenting pre and post training?)
(c) Is there any change in attitude towards residential care among parents, extended family and community members?	Attitudes of parents, extended family and community members towards institutional care	
Evaluation Question 5: By project end to what extent have functioning structures, workforce and services been established that can continue to provide on an ongoing basis adequate case management services for children at risk?		
(a) Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?	<ul style="list-style-type: none"> ▪ Perceived attitudes of gov. authorities, state, and non-state service providers ▪ Perception of knowledge and skills of gov. authorities, state, and non-state service providers ▪ % of trained gov. authorities and state and non-state service providers that demonstrate adequate knowledge 	<ul style="list-style-type: none"> ▪ Total # of trained gov. authorities and state and non-state service providers ▪ # of trained gov. authorities and state and non-state service providers demonstrating adequate knowledge ▪ KAP of officials and service provided that have been trained by the project

Indicator		Indicator Computation Variables
(b) Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?	Approach used to build family resilience and involve, support, and protect children at the local level	
Evaluation Question 6: Did the project offer models and approaches for expansion, adaptation, and/or replication?		
(a) Were lessons learned widely discussed and disseminated during project implementation?	<ul style="list-style-type: none"> ▪ Mechanism for sharing lessons learned ▪ The extent to which lessons learned were disseminated 	
(b) Were any best practices or successful techniques institutionalized?	<ul style="list-style-type: none"> ▪ Perceived knowledge of new best practices among project partners, stakeholders, and beneficiaries (as evidenced through analysis to answer above evaluation questions) ▪ Opinions of adoption of new best practices or techniques among project partners, stakeholders, and beneficiaries 	

Exhibit 2: Child wellbeing indicators

No	Wellbeing element	Indicators
I.	Materials: -shelter -clothing	Shelter The child has personal space facilitated by: <ul style="list-style-type: none"> – Necessary conditions for sleeping; – Conditions for doing homework; – Conditions for play and toys. Accommodation (house, apartment) should be: <ul style="list-style-type: none"> – Heated during the cold season of the year, – Illuminated, especially in the zone where the child does his/her homework, – To be connected to electricity, gas (if the place is gasified), – To be provided access to drinking water. The dwelling should be facilitated by: <ul style="list-style-type: none"> – Space for meals, – Conditions for leisure time, – Conditions for personal hygiene, – Conditions for washing. The house is clean; there should be washing powder in the household. Personal hygiene items: The child has at his/her disposal the following items of personal hygiene: toothbrush, comb, a small towel for hands, a big towel for the body. He/she has access to the toothpaste, soap, shampoo, and scissors.

No	Wellbeing element	Indicators
		<p>Clothing: The child has clothing for each season of the year according to his/her age, thus for one-year time the child roughly should be provided with:</p> <ul style="list-style-type: none"> - Winter time – thick outer clothing, a cap, a scarf, mittens, warm boots, pullover, a shirt/blouse, pants/a warm dress, tights and warm socks, thick nightgown/ pajamas; - Autumn (fall) and spring - waterproof jacket and footwear, a cap, a pullover, a shirt/a blouse, pants/autumns dress, tights and socks; - Summer – pants/ shorts/cotton dress, t-shirts, sandals, a summer cap; - Irrespective of the season the child should have the following clothing for school – a set of clothes for school, sports suits and footwear, underclothing, handkerchief.
2.	<p>Psychosocial: -secure relationships -consistent engagement in age appropriate recreational, cultural and educational activities Does the child display aggressive, distressed or depressed behavior</p>	<p>The child develops emotionally and socially according to his/her age.</p> <ul style="list-style-type: none"> - The child has a sense of identity and belonging; - The child is confident; - The child has self-care skills; - The child expresses his/her emotions by socially accepted behaviour; - The child copes with traumatic events of loss and separation; - The child respects other children, he/she is not involved in persecution and discrimination of other children; - The child is not worried because of the fear towards somebody or something; - The child doesn't manifest behavior of self-mutilation or suicide tentative. <p>The child is in good relationships with parents/carers, siblings, other members who live together:</p> <ul style="list-style-type: none"> - There is a strong attachment and affectivity on behalf of the parent/carer and other family members; - Has an adult person/persons (social support network) among family members, carers or friends with whom they can talk, share joy or express their anxiety, uneasiness; <p>The child is involved in diverse activities in the family, social network, school and community, including cases of children with chronic disease or disability. The child understands and respects social norms and traditions applied in his/her environment; The parent ensures a balance between learning activities, recreation for the recovery of physical and mental potential to avoid extenuation.</p>
3.	<p>Educational: -Access to school -Grades -Regular attendance Specific issues for children with disabilities</p>	<p>The child is integrated in the educational process – pre-school institution, school (including at home studying), vocational school etc. according to his/her age, with children of his/her age;</p> <p>The child attend pre-school or school systematically; The child has passing grades. In case of poor school progress the child has access to teaching support. The child with special needs has a worked out individual educational plan, which is put in application; The child with special educational needs benefits from the services of resource centers within the school; The child is supported by the parents/carers in educational process for doing his/her homework, involvement in school, extra-curricular and community activities; Educational environment is inclusive, stimulating and friendly.</p>
4.	<p>Safety: This looks at whether the child is</p>	<p>The child is not threatened or exposed to physical abuse or violence at home, at school or in community; The child is not exposed to emotional abuse at home, at school and in community; The child feels safe at home, at school and in community;</p>

No	Wellbeing element	Indicators
	protected from: -Violence (physical and verbal) -Abuse (physical and verbal) -Neglect in the home, school and community environment	The child is not physically neglected by the parent/carer (the child is fed, has shelter and clothing, is provided with hygiene and has access to medical and dental services); The child who cannot take care of himself/herself is not left unattended, is not left in the care of the other child or other persons who can't provide safety to the child; The child is not neglected emotionally, is in permanent contact with the reference adult, who provides support, who the child trusts, is protected and guided by the parent/carer; The child is not exposed to alcohol/drug abuse on behalf of the family members or other persons in community; The child is not exposed to persecution or discrimination by other schoolmates or adults at schools, in community; The child is not exposed to sexual abuse or exploitation; The child doesn't feel being pushed by other children or adults to make dangerous actions; The child is not exposed to or involved in anti-social or criminal activities in the community; The child knows, takes protection measures and acts responsibly in potential risk situations; The child is supported and manifests resilience in different hard circumstances at home; The child is informed about the forms and signs of abuse, neglect and exploitation; Parents/carers are informed about the forms and signs of abuse, neglect, exploitation and about applying non-violent forms of managing challenging behavior of the child; The child is not involved in manufacturing, transporting, purchasing and selling alcohol, cigarettes, toxic and narcotic substances; The child is not involved in economic activities and hard work that could harm his/her physical, mental and moral development of the child.
5	Health and nutrition: -Food intake -Sickness -Access to health care	The child is registered with the family doctor (has health record, is vaccinated); The child is medical and dentally examined; The child's physical development parameters (weight and height) correspond to his/her age; The child with health issues, chronic or long-term diseases, including disability makes regular checks, takes necessary treatment, respects a regime upon need, accesses necessary health and social services; The parent/carer knows and understands the child's health needs; The child knows and understands the needs that refer to his/her own health and is trained to provide self-care in the limits of his/her potential; The child doesn't smoke or drink alcohol, misuse drugs or other toxic substances; The child has a sexual behaviour appropriate to his/her age and development stage; The child is fed three times per day, provided at least with a warm meal per day in sufficient quantities, according to his/her age; In child's nutrition there are quality and nutritional products, drinking water, which are appropriate to the child's age and his/her individual needs; The child is involved in choosing and cooking meals depending on his/her age; The parent knows and understands nutritional needs of the child, including the child's individual health needs; The child knows and understands nutritional needs and is trained to respect necessary regime;

ANNEX III: EVALUATION METHODS AND LIMITATIONS

To gather data required for this evaluation, NORC's Evaluation Team used several techniques which entailed a mix of mutually reinforcing qualitative and quantitative methods that reflect the program design, research questions being addressed, and indicators. We combined the results of each technique to capture the diversity of opinions and perceptions of beneficiaries and stakeholders about key children/family care and protection issues at the start of the program. The qualitative analysis, which includes key informant interviews (KII) and focus group discussions (FGD), provides the local context and represents concrete examples that illustrate in greater detail the quantitative findings. Our approach to selecting the appropriate methodology is based on the USAID Evaluation Policy as well as our experience conducting evaluations in the field.

NORC Evaluation's Team conducted the evaluation in a participatory manner which involved engaging USAID/DCOF, implementing partner P4EC, program beneficiaries, and other stakeholders. A complete list of documents the Evaluation Team reviewed is included in Annex V, Sources of Information.

EVALUATION MANAGEMENT

The evaluation team for Moldova include Ritu Nayyar-Stone (Project Director), Mawadda Damon Gartner (Evaluator), N. Beth Bradford (Subject Expert) and Huyen Le. (Research Analyst). Veronica Pelivan provided logistical support and was the note taker for KIIs in Moldova, and Graduate research assistant from the Harris School of Public Policy at Chicago, Carolina Mendez provided research support during analysis. Local data collection was undertaken by Institutul de Marketing si Sondaje "IMAS-INC" SRL (IMAS) who conducted the FGDs and administered the evaluation survey. As a measure to ensure high data quality, NORC provided targeted training to IMAS for FGDs and survey administration/quality control; undertook a data quality review of the received data; and did all the analysis.

STUDY DESIGN

Primary and Secondary Data Collection

The study design required NORC to depend solely on P4EC to obtain information on the wellbeing of children (i) currently in RCCs and (ii) in vulnerable families, due to concerns about contacting families and RCCs directly. NORC and P4EC worked closely together to develop indicators of child wellbeing, and P4EC worked on building the capacity of social workers to obtain child wellbeing information for case management purposes.

The evaluation therefore comprises of primary data collection by NORC in the form of KIIs, FGDs, and a survey of community social workers and specialists of the SAFFPD/social work specialists who are the direct beneficiaries of the project; and the use of secondary data collected by P4EC – child wellbeing indicators, a Knowledge Aptitude and Practice (KAP) survey, and capacity building training of stakeholders.

Confidentiality

All evaluators and program staff were asked to sign a confidentiality agreement prior to working on the evaluation. Copies of the signed statements are available upon request.

Further, as part of the data collection training, the Evaluator included a substantive Confidentiality Training component for IMAS's survey and FGD team. Each individual on the data collection team was asked to read aloud together, understand, and sign NORC's Pledge of Confidentiality Compliance before

being accepted to work on the program. Signed copies from each field staff are securely filed with NORC, as is required by NORC's Institutional Review Board (IRB).

Introduction and Informed Consent

In addition to the Evaluation Team and Survey Administration Team's pledge of confidentiality, each FGD and Survey Questionnaire began with an informative introductory statement that describes to respondents the subject of the survey and some basic details about the confidential and voluntary nature of their participation. For example, the introduction informed respondents about the P4EC project and the purpose of the survey; the client and evaluators; and a statement that their participation is voluntary, that their responses will remain confidential and used in aggregated summaries only, that they may skip questions they don't feel comfortable answering; and time required to complete the FGD or survey. We provide this information to respondents so that they may give an informed consent to participate, which is consistent with NORC's professional commitment as members of the American Association for Public Opinion Research (AAPOR). Evaluation instruments for KIs, FGDs and the Survey are included in Annex IV.

Evaluation Instrument Development

NORC drafted and finalized the data collection tools (key informant interview protocols, focus group protocols, and survey questionnaires) for Moldova. These were shared with DCOF and the implementing partner for their feedback prior to finalization. The tablet-based surveys in Moldova was programmed by IMAS and tested prior to beginning enumerator training. NORC developed all training materials and Evaluation Expert Mawadda Damon and Subject Area Expert Beth Bradford traveled to Moldova from 02/18-27/2015 to conduct the training for FGD and survey enumerators and do some KIs with P4EC staff and other stakeholders

TARGET POPULATION

The quantitative survey targeted the community social workers (CSW) and specialists of the SAFPD or "social work specialists" in the 10 project raions for P4EC.

Qualitative data collection consisted of a series of 30 focus groups led by our subcontractor, IMAS, and 43 key informant interviews conducted primarily by Beth Bradford. Additional key informant interviews were conducted by Mawadda Damon and Veronica Pelivan. The team visited six project raions: Soroca, Telenesti, Singerei, Causeni, Ungheni, and Cahul. All interviews and focus groups were recorded where possible. All transcripts were translated into English by IMAS and coded into NVIVO by NORC for data analysis.

Exhibit I. Moldova Focus Group Summary

Raion location of FGD	Number	Target
Cahul	3	Advisory Board of Children Parents – of children at-risk of separation Multidisciplinary teams
Căușeni	2	Community social workers Girls 15-17
Călărași	1	Advisory Board of Children
Chișinău	2	Gatekeeping Commission (Orhei+Nisporeni+Calarasi) Social Work Specialists (Orhei+Nisporeni+Calarasi)
Fălești	2	Gatekeeping Commission (Ungheni+Fălești) Girls 12-14
Nisporeni	3	Boys 12-14 Mayors Parents – children in Residential Care Centers
Orhei	2	Girls 15-17 Parents – deinstitutionalized children
Șîngerei	4	Community social workers Multidisciplinary teams Boys 15-17 Parents – of children at-risk of separation
Soroca	4	Community social workers Girls 12-14 Mayors Parents – children in Residential Care Centers
Ungheni	5	Boys 15-17 Parents – deinstitutionalized children Social Work Specialists (Ungheni+Falesti) Mayors (Ungheni+Fălești) Community social workers (Ungheni+Fălești)
Telenești	1	Boys 12-14
Total	29	

Exhibit 2. Moldova Key Informant Interview Summary

No.	Title / Organization-Agency / Raion
1.	Department of Pre-University Education, Ministry of Education
2.	Department of Mother and Child, Ministry of Health
3.	Dean, Faculty of Social Work, Moldova State University
4.	Director, P4EC
5.	Project Team Leader, P4EC
6.	Child Participation Specialist, P4EC
7.	Public Finance Reform Specialist, P4EC
8.	Communications Specialists, P4EC
9.	Training Specialist, P4EC
10.	Site Coordinator, P4EC
11.	Site Coordinator, P4EC
12.	Site Coordinator, P4EC
13.	Site Coordinator, P4EC
14.	Site Coordinator, P4EC
15.	Project Coordinator, Terre des hommes Moldova
16.	Vice President on Social Issues, Raion Council Soroca
17.	Head of Social Assistance and Family Protection, Soroca
18.	Child and Family Protection Specialist, Soroca
19.	Head of Education Department, Soroca
20.	RCC Director, Soroca
21.	Vice President on Social Issues, Telenesti
22.	Head of Social Assistance and Family Protection, Telenesti
23.	Child and Family Protection Specialist, Telenesti
24.	Child Protection Specialist, Telenesti
25.	Manager of Community Social Assistance, Telenesti
26.	Head of Education Department, Telenesti
27.	Vice President on Social Issues, Singerei
28.	Head of Social Assistance and Family Protection, Singerei Child and Family Protection Specialist

No.	Title / Organization-Agency / Raion
29.	Manager of Community Social Assistance, Singerei
30.	Child Protection Specialist, Singerei
31.	Head of Education Department, Singerei
32.	Head of Social Assistance and Family Protection, Causeni
33.	Deputy Head of Education Department, Causeni
34.	Vice President on Social Issues, Causeni
35.	Child and Family Protection Specialist, Causeni
36.	Manager of Community Social Assistance, Ungheni
37.	Vice President on Social Issues, Ungheni
38.	Head Social Assistance and Family Protection, Ungheni
39.	Head of Social Assistance Department, Ungheni
40.	Vice President on Social Issues, Cahul
41.	Child Protection Specialist, Cahul
42.	Director of Crihana Veche, Residential Care Center, Cahul

SAMPLING

NORC included the full sample frame of all male CSWs and all the social work specialists in the 10 project raions. Where the total number of CSWs (male and female) was less than 32 NORC included all the CSWs (Calarai (31), Causeni (31), Nisporeni (26), and Singerei (28)). In the remaining 6 project raions we randomly selected a total of 30 CSWs – first including all the males and then randomly selecting among the females. This resulted in a sample of 296 CSWs and 38 social work specialists. When contacted, some of the respondents in the sample were no longer eligible, having left the service and employed elsewhere; giving us a total eligible sample of 311 and the total number of actual respondents as 300 of which 264 were CSWs and 36 social work specialists.

Exhibit X. Moldova Social Worker Survey Summary

Raion	Sample Size	Sample Frame		
		CSW Male	CSW Female	Specialists
Cahul	34	3	45	4
Călărași	35	2	29	4
Căușeni	34	0	31	3
Fălești	36	2	34	7
Nisporeni	29	2	24	3
Orhei	36	0	42	5
Sîngerei	30	2	26	2
Soroca	34	6	33	4
Telenesti	32	3	32	2
Ungheni	34	6	33	4
Total	334	26	329	38
Number of respondents	300			
Number of eligible cases	311			
Response rate*	96%			

*NORC uses the AAPOR standard to calculate response rates where the numerator is the number of completed cases and the denominator is the number of eligible cases in the sample.

LIMITATIONS

The Evaluation Team encountered some limitations inherent to the design of this evaluation and during its fieldwork in Moldova. Some of the more relevant limitations are listed below:

- **Biases in data collection methodologies.** To identify key stakeholders and program beneficiaries, the Evaluation Team relied on assistance from P4EC staff. The locations for FGDs and raion visits for KIIs were chosen independently by NORC (after discussion of the selection criteria with P4EC); however FGD participants and interviewees were suggested by P4EC.
- **Reluctance to respond to survey.** The data collection team faced reluctance from CSWs and social work specialists to participate in the surveys. Despite our messaging to the contrary, word of the survey was circulated among social workers in regions where our team had not yet arrived, along with the wrong perception that it was a test of their knowledge; and thus their heads of department started to put up barriers to the data collection such as insisting on being present for each interview. Our local data collection firm, IMAS, worked hard to correct this false information and convince the heads of the department and social workers that we are evaluating the program and not them, which they eventually managed to do.
- **Baseline timeframe.** The program started in January 2014, but NORC's concept note for the evaluation was approved by mid-June 2014; the evaluation design was completed by December 2014; and the data collection was undertaken in March-April 2015. Thus some amount of program implementation had already started prior to the baseline.
- **Administrative and M&E data from the implementer.** P4EC has been conscientious regarding data collection, making great efforts to work with the CSWs to collect important data on child demographics, wellbeing, family status, etc. However, lack of sufficient skills in following rigorous data quality assurance practices resulted in too few observations for certain indicators and inconsistency across districts, sometimes making the data unusable.
 - a. **Data on children in RCCs.** (1) Several instances where the indicators and measurements differ across districts: For example, to monitor the "negative emotions" of the children,

- P4EC's "codebook" in Cahul, Ciniseuti, and Hirbovat asks if the child displays the following emotions: "a) aggressiveness ; b) anxiety; c) upset/concern with something; d) does not display." Yet, in Nisporeni, the label was "The child display aggressiveness, distressed, or depressed behavior: a) Doesn't display; b) Often (every day, every week); c) Seldom (once a month)." Due to this difference, Nisporeni was excluded from our analysis on "negative emotions" displayed by the children in RCCs. That also explains why the total number of cases are not the same in our descriptive statistics report. (2) Some of the data was very difficult to interpret. For example, for information collected about the child's opinion about reintegration, in Nisporeni and Cahul, we found cases where the child "wants home" and "does not want home" at the same time, which was likely due to data entry errors. Therefore, for all logic errors, we coded them to missing. (3) In addition to analyzing the project at the child level we also wanted to evaluate the project at the family level (for example, how many children come from families that experience alcohol abuse, domestic violence, etc. or how many children per family are being affected by the project?) Although P4EC has invested in collecting family information such as employment status of parent, family issues, etc., they didn't create family identification and organize the data in a way that allows it to be aggregated into family level.
- b. **Data on children in vulnerable families.** P4EC provided NORC with 11 files containing information on vulnerable children staying with their family in 11 districts, namely Orhei, Nisporeni, Soroca, Falesti, Cahul, Calarasi, Causenti, Rezina, Singerei, Telenesti, and Ungheni. Similar to the RCC data, these files were inconsistent not only the structure of the dataset, but also in the information they collected, coding, etc. For example, (1) the data includes dates of birth of as "1905" or children older than 18. (2) The formats of date of birth are different across the files; some were displayed as MM/DD/YYYY while others were displayed it DD/MM/YYYY, making it very difficult to assemble 11 files into one comprehensive dataset. (3) There were several duplicates such as date of birth, gender, form at the moment of evaluation, child status, etc. were identical for children with different case numbers. (4) We would not commonly expect children under five to be in elementary school, yet for these children we saw data about "the child having poor grades, but is striving." All of these factors created doubt about the quality of data and an inability to clean over 4000 observations. NORC was unable to use this valuable source of information in the baseline analysis.

The above limitations, however, did not prevent the Evaluation Team from gathering the information and data needed to produce findings, and conclusions for this baseline performance evaluation.

ANNEX IV: DATA COLLECTION INSTRUMENTS

The NORC evaluation team employed three instruments to collect primary data.

1. Survey Questionnaire: The questionnaire below is in the format tailored to Computer-Assisted Personal Interviewing (CAPI) methods.
2. Protocols for the following Focus Group Discussions:
 - a. FGD with ABC Children's Group
 - b. FGD with Children
 - c. FGD with Community Social Assistants
 - d. FGD with Social Work Specialists
 - e. FGD with Gatekeeping Commissions
 - f. FGD with Mayors
 - g. FGD with Multidisciplinary Teams
 - h. FGD with Parents
3. Protocols for the following groups of Key Informant Interviews:
 - a. National KII Protocol
 - b. RCC KII Protocol
 - c. Regional KII Protocol
 - d. Staff KII Protocol

SURVEY OF SOCIAL WORKERS

(Community Social Workers and Social Workraion Specialists)

INTRO. PROG: PLEASE DISPLAY THE FOLLOWING MESSAGE ON ITS OWN PAGE:

Hello, my name is _____ from the Institute of Marketing and Polls IMAS-INC Chisinau (IMAS). We are working with NORC at the University of Chicago on an evaluation of **Partnership for Every Child's Program** that is making sure children in Moldova are cared for in safe and secure families. The program and this evaluation are funded by The United States Agency for International Development - USAID. This program started in January 2014 and will continue until June 2017.

We are asking you to participate in a 40-minute survey in order to obtain your feedback on the child care and protection system in your raion and community and information on your experience as a social worker. You have been selected for this survey because you are participating in Partnership for Every Child's program. We are asking your opinions now, at the start of the program, and will be returning to ask you to continue participating in our evaluation and provide your opinions next year and then once again at the end of the program.

Your feedback will be very important to us and to Partnership for Every Child. The information you provide will be used to improve Partnership for Every Child's current and future programs and will inform future programming funded by USAID.

Your participation in this survey is voluntary and you may choose to skip a question or discontinue your participation at any time without any penalty. Your identity will be kept confidential and will not be shared with Partnership for Every Child. We will keep your contact information in order to contact you to obtain your feedback until the end of the program. If you have any questions about the survey, you may contact Serviciul de Operatiuni Teren IMAS at tel: 022 26 00 96

May we start now?

1 Yes

2 No **PROG: SKIP TO CLOSURE**

PROG: INSERT NEXT, PREVIOUS, STOP BUTTONS ON THIS AND SUBSEQUENT PAGES

PROG: COLLECT TIME STAMP DATA UPON ENTRY OF THIS PAGE, AND AT THE END OF EACH SECTION

PROG: END MESSAGE

PROG: BEGIN FIELD CONTROL SECTION:

FIELD CONTROL		
ID.	Respondent ID:	<input type="text"/> PROG: DROP BOX WITH ALL IDs
RAION	Raion ID:	10 raions listed, select one
LOC.	Locality ID:	<input type="text"/> PROG: DROP BOX WITH ALL LOCALITIES
LIMBA	Language	<input type="text"/> Choice of Romanian or Russian
COD_OP.	Interviewer ID:	<input type="text"/> PROG: NUMBER [RANGE]

PROG: END FIELD CONTROL.

ENUMERATOR: READ OUT RESPONSE OPTIONS UNLESS OTHERWISE STATED

PROG: NOTE ALL QUESTIONS WILL ALSO HAVE A DON'T KNOW=-1, REFUSED=-2, and NOT APPLICABLE=-3 OPTION.

NOTE: Those who answer 1 to Question 5 (meaning they are social workers) will answer questions about/at community level. Those who answer 2 to question 5 (meaning they are specialist) will answer questions about/at raion level.

SECTION I: DEMOGRAPHICS

1. GENDER. Sex. ENUMERATOR: DO NOT READ RESPONSES. CODE FROM RESPONSE OPTIONS.

- 1 Male
- 2 Female

2. AGE. How old are you?

_____ **PROG: NUMBER [1-110]**

3. EDU. What is your highest level of education completed?

- 1. Less than 11 years of schooling **PROG: SKIP TO 5: JOB**
- 2. 11 years of schooling **PROG: SKIP TO 5: JOB**
- 3. High school **PROG: SKIP TO 5: JOB**
- 2. College
- 3. University
- 4. Master Degree

4. EDU_MASTER. PROG: ASK IF EDU=4 What is your degree area?

- 1. Social work
- 2. Education
- 3. Medicine
- 4. Law
- 5. Public Administration
- 6. Other related Social Field: _____ **PROG: OPEN ENDED FIELD**
- 7. Other unrelated field: _____

5. JOB. What is your job title? ENUMERATOR: DO NOT READ ANSWER OPTIONS. IF IS COMMUNITY SOCIAL WORKER, SELECT 1, IF ANY OF THE RAION LEVEL POSITIONS, SELECT 2

- 1. Community Social Worker
- 2. Specialists of the SAFPD or "Social work specialist"

6. RAION_GEO. In what raion do you work?

PROG: DROP BOX WITH ALL RAISONS

7. **COM_GEO.** In what community do you work?

PROG: DROP BOX WITH ALL COMMUNITIES

8. **YEAR_POS.** How many years have you been in your position? **ENUMERATOR: IF RESPONDENT DOES NOT REMEMBER THE EXACT NUMBER OF MONTHS, PLEASE ENTER ONLY THE NUMBER OF YEARS. IF THEY WORK LESS THAN A YEAR, PLEASE ASK FOR THE NUMBER OF MONTHS.**

_____ YEAR _____ MONTH **PROG: YEAR, RANGE 1-40.**
MONTH: 1-12

PROG: END SECTION I (PLEASE COLLECT TIME STAMP)

SECTION 2: OPINIONS ON SUPPORTS TO CHILDREN

ENUMERATOR: PLEASE READ OUT LOUD. I will now ask you a series of questions about the services that are available in your raion/community.

9. **SERVICES_RAION.** Which of the following services to support vulnerable families are available in your *raion*?

	1= Yes	2= No
A. Financial assistance – government cash assistance / other social assistance programs		
B. Financial assistance – nongovernment		
C. Case management for families at-risk		
D. Parenting support services (parenting education, support groups, etc.)		
E. Other family support (please specify)		
F. Mental health counseling (for parents, for children, for both)		
G. Substance use/abuse services		
H. Housing assistance services		
I. Employment / income generation services		
J. Public schooling for children		
K. Job skills training programs for adults		

L. Continuing education for adults		
M. Daycare services		
N. Kindergartens		
O. Creche		
P. Respite care for children with disabilities (APP respiro)		
Q. Special services for children with disabilities		
S. Juvenile delinquency prevention programs		
T. Other service (please specify) ENUMERATOR: Ask if there are any services that have not been mentioned		

10. SERVICES_COM. Which of the following services to support vulnerable families are available in your *community*?

	1= Yes	2= No
A. Financial assistance – government cash assistance / other social assistance programs		
B. Financial assistance – nongovernment		
C. Case management for families at-risk		
D. Parenting support services (parenting education, support groups, etc.)		
E. Other family support (please specify)		
F. Mental health counseling (for parents, for children, for both)		
G. Substance use/abuse services		
H. Housing assistance services		
I. Employment / income generation services		

J. Public schooling for children		
K. Job skills training programs for adults		
L. Continuing education for adults		
M. Daycare services		
N. Kindergartens		
O. Creche		
P. Respite care for children with disabilities (APP respiro)		
Q. Special services for children with disabilities		
R. Juvenile delinquency prevention programs		
S. Other service (please specify) ENUMERATOR: Ask if there are any services that have not been mentioned		

11. SER_RAION_ADE. How adequate do you believe the services in your *raion* generally are to meet the needs of families to help ensure that children can stay in or be returned to family care?

1. Fully adequate
2. Somewhat adequate
3. Not at all adequate **PROG: SKIP TO 13. SERVICE_RAION_ADE_B**

12. SER_RAION_ADE_A. PROG: ASK IF 11. SERVICE_RAION_ADE = 1 OR 11. SERVICE_RAION_ADE = 2 What makes them adequate? *Please choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. A wide range of services exists
2. Services are community-based
3. Services are accessible to all families
4. Families are aware of the services
5. Services are designed based on the needs of family
6. Professionals are well prepared to work with families in these services
7. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

PROG: UPON ENTRY, SKIP TO 14. SER_RAION_NEED IF SER_RAION_ADE=1.

13. SER_RAION_ADE_B. PROG: ASK IF 11. SER_RAION_ADE = 2|11.SER_RAION_ADE=3 What are the reasons that services do not fully meet the needs of families? *Please choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Services are not in place at all
2. Too few services are in place to meet the needs
3. Families cannot access the services
4. Families do not know about the services
5. Services do not match the needs of families
6. Family needs are complex and cannot be met by existing services
7. Professionals running the services are not proficient at working with families
8. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

14. SER_RAION_NEED. Are there any services that are strongly needed in your raion that are not available?

1. Yes
2. No **PROG: SKIP TO 16. SER_COM_ADE**

15. SER_RAION_NEED_A. PROG: ASK IF 14. SER_RAION_NEED = 1. What are the services that are strongly needed in your raion but are not available?

1. Financial assistance – government cash assistance / other social assistance programs
2. Financial assistance – nongovernment
3. Case management for families at-risk
4. Parent support services (parenting education, support groups, etc.)
5. Other family support (please specify)
6. Mental health counseling (for parents, for children, for both)
7. Substance use/abuse services
8. Housing assistance services
9. Employment / income generation services
10. Public schooling for children
11. Job skills training programs for adults
12. Continuing education for adults
13. Daycare services
14. Kindergartens
15. Creche
16. Respite care for children with disabilities (APP respiro)
17. Special services for children with disabilities
18. Juvenile delinquency prevention programs
19. Other service, please specify _____ **PROG: OPEN-ENDED FIELD**

16. SER_COM_ADE. How adequate do you believe the services in your community generally are to meet the needs of families to help ensure that children can stay in or be returned to family care?

1. Fully adequate
2. Somewhat adequate

3. Not at all adequate

PROG: GO TO 18. SERVICE_COM_ADE_B

17. SER_COM_ADE_A. PROG: ASK IF 16. SER_COM_ADE = 1 OR 16. SER_COM_ADE = 2 What makes them adequate? *Please choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. A wide range of services exists
2. Services are community-based
3. Services are accessible to all families
4. Families are aware of the services
5. Services are designed based on the needs of family
6. Professionals are well prepared to work with families in these services
7. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

PROG: UPON ENTRY SKIP TO 19. SER_COM_NEED IF 16. SER_COM_ADE=1.

18. SER_COM_ADE_B. PROG: ASK IF 16. SER_COM_ADE = 2 | 16. SER_COM_ADE= 3 What are the reasons that services do not fully meet the needs of families? *Please choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Services are not in place at all
2. Too few services are in place to meet the needs
3. Families cannot access the services
4. Families do not know about the services
5. Services do not match the needs of families
6. Family needs are complex and cannot be met by existing services
7. Professionals running the services are not proficient at working with families
8. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

19. SER_COM_NEED. Are there any services that are strongly needed in your community that are not available?

1. Yes **PROG: SKIP TO 21. SER_SPECIAL_POP**
2. No

20. SER_COM_NEED_A. PROG: ASK IF 19. SER_COM_NEED = 1 What are the services that are strongly needed in your community but are not available? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Financial assistance – government cash assistance / other social assistance programs
2. Financial assistance – nongovernment
3. Case management for families at-risk
4. Parent support services (parenting education, support groups, etc.)
5. Other family support (please specify) _____
6. Mental health counseling (for parents, for children, for both)
7. Substance use/abuse services
8. Housing assistance services

9. Employment / income generation services
10. Public schooling for children
11. Job skills training programs for adults
12. Continuing education for adults
13. Daycare services
14. Kindergartens
15. Creche
16. Respite care for children with disabilities (APP respiro)
17. Special services for children with disabilities
18. Juvenile delinquency prevention programs
19. Other service, please specify _____

PROG: OPEN-ENDED

FIELD

21. SER_SPECIAL_POP. In general please rate how adequate existing services are to meet the needs of each of the following special populations of families in your raion/community:

	1. Fully Adequate	2. Somewhat adequate	3. Not at all adequate
A. Single mothers			
B. Kinship care givers – guardians (For example, grandmothers)			
C. Families with substance use/abuse issues			
D. Families with children with disabilities			
E. Families living in poverty			
F. Families at risk of living in poverty			
G. Teenage parents			
H. Children left behind by migratin parents			
I. Families with children with disabilities or special education			
J. Children from ethnic minorities groups			

<p>K. Others, please specify specify ENUMERATOR: Ask if there is any other special population and then ask them to rate how adequate existing service is for this group</p> <hr/> <p>PROG: OPEN-ENDED FIELD</p>			
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22. SER_ACCESS. Are families in need generally able to access the services in your raion/community provided to help ensure that children can stay in or be returned to family care?

- 1. Yes, all families **PROG: SKIP TO 25. SER_ACCESS_RATE**
- 2. Yes, most families **PROG: SKIP TO 25. SER_ACCESS_RATE**
- 3. Yes, some families
- 4. No

23. SER_ACCESS_NO. PROG: ASK if 22. SER_ACCESS = 3 OR 22. SER_ACCESS = 4.
Which services are generally not accessible to families in need in your raion/community? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1. Financial assistance – government cash assistance / other social assistance programs
- 2. Financial assistance – nongovernment
- 3. Case management for families at-risk
- 4. Parent support services (parenting education, support groups, etc.)
- 5. Other family support (please specify)
- 6. Mental health counseling (for parents, for children, for both)
- 7. Substance use/abuse services
- 8. Housing assistance services
- 9. Employment / income generation services
- 10. Public schooling for children
- 11. Job skills training programs for adults
- 12. Continuing education for adults
- 13. Daycare services
- 14. Kindergartens
- 15. Creche
- 16. Respite care for children with disabilities (APP respiro)
- 17. Special services for children with disabilities
- 18. Juvenile delinquency prevention programs
- 19. Other service (please specify) _____ **PROG: OPEN-ENDED FIELD**

24. SER_ACCESS_REASON. PROG: ASK if 22. SER_ACCESS = 3 OR 22. SER_ACCESS = 4. What are the reasons that these services are not accessible? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Service does not exist in family's community
2. Distance – services are too far for families to reach
3. Physical accessibility – due to physical disability family cannot get to the service (example lack of access ramps to building)
4. Transportation issues
5. Cost prohibitive
6. Stigma attached to services
7. Working hours offered do not meet family's schedule
8. Language barrier – service is not offered in family's language
9. Other , please specify _____ **PROG: OPEN-ENDED FIELD**

25. SER_ACCESS_RATE. For each of the following special populations of families, please rate their level of access to existing services.

	1 = Services accessible to all families	2 = Services accessible to most families	3 = Services accessible to some families	4 = Services not accessible to any families
A. Single mothers				
B. Kinship care givers – guardians (For example, grandmothers)				
C. Families with substance use/abuse issues				
D. Families with children with disabilities				
E. Families living in poverty				
F. Families at risk of living in poverty				
G. Teenage parents				
H. Children left behind by migratin parents				

I. Families with children with disabilities or special education				
J. Children from ethnic minorities groups				
K. Others, please specify specify ENUMERATOR: Ask if there is any other special population and then ask them to rate how adequate existing service is for this group				
PROG: OPEN-ENDED FIELD				

26. ALT_CARE. What types of alternative care are in place in your raion/community to meet the needs of children without adequate parental care? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Guardianship
2. APP
3. CCTF
4. Community group home
5. Adoption
6. Emergency/temporary placement center
7. Boarding schools
8. Other resident institution (not boarding school)
9. Others, please specify _____ **PROG: OPEN-ENDED FIELD**

PROG: BEGIN ALTERNATIVE CARE RATING LOOP TO BE APPLIED ON EACH OPTION CHOSE IN 26. ALT_CARE

27. ALT_CARE_RATE. How would you rate the quality of the service?

1. Excellent
2. Good
3. Fair
4. Poor

PROG: END ALTERNATIVE CARE RATING LOOP.

28. DEPT_CHILD_SUPPORT. Does your department provide support to children?

1. Yes

2. No **PROG: SKIP TO 31 DEPT_CAREGIVER_SUPPORT**

29. DEPT_CHILD_SUPPORT_A. PROG: ASK IF 28. DEPT_CHILD_SUPPORT = 1. What supports are provided to children? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Services to address visual/auditory disabilities

2. Services to address cognitive/learning disabilities

3. Services for mental health issues

4. Family support

5. Counselling

6. Material support (for example, school supplies)

7. Referral to services to address physical/mobilities disabilities

8. Referral to health services

9. Referral to special education support

10. Referral to early childhood support

11. Referral to child care

12. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

30. DEPT_CHILD_SUPPORT_B. PROG: ASK IF 28. DEPT_CHILD_SUPPORT = 1. To what extent do you believe the support provided to children is effective?

1. Effective

2. Somewhat effective

3. Not at all effective

31. DEPT_CAREGIVER_SUPPORT. Does your department provide support to caregivers (the person responsible for the care of the child including biological parents, guardians, foster parents, etc)?

1. Yes

2. No **PROG: SKIP TO 34. SER_ACCESS_RESULT**

32. DEPT_CAREGIVER_SUPPORT_A. PROG: ASK IF 31. DEPT_CAREGIVER_SUPPORT = 1. What supports are provided to caregivers? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Access to cash benefits or other financial assistance

2. Family case management

3. Counselling

4. Social/psychological services for people with mental health issues

5. Disability services for children

- 6. Parenting education
- 7. Referral to services
- 8. Referral to specialist health care
- 9. Referral to child care
- 10. Referral to alcohol or substance abuse treatment
- 11. Other, please specify _____

PROG: OPEN-ENDED FIELD

33. CARE_GIVER_SUPPORT_B. PROG: ASK IF 31. DEPT_CAREGIVER_SUPPORT = 1.

To what extent do you believe the support provided to caregivers by service providers improves their caregiving?

- 1. Greatly improves
- 2. Somewhat improves
- 3. Does not improve

34. SER_ACCESS_RESULT. In general, as a result of access to family support services, do you see the families' ability to care of their children as:

- 1. Improving considerably
- 2. Improving some
- 3. Staying the same
- 4. Not improving much
- 5. No change

35. SER_TOP3. In your opinion, what are the top three support services to families that are the most effective to improving a families' ability to care for their children? *Choose only three.* **PROG: ALLOW UP TO THREE CHOICES.**

- 1. Cash benefits or other financial assistance
- 2. Family case management
- 3. Referral to services
- 4. Counseling
- 5. Social/psychological services for people with mental health issues
- 6. Specialist health care
- 7. Child care
- 8. Disability services for children
- 9. Alcohol and substance abuse treatment
- 10. Parenting education
- 11. Other, please specify _____

PROG: OPEN-ENDED FIELD

36. SER_IMPROVE. Which support services to families do you feel can be improved? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Cash benefits or other financial assistance
2. Family case management
3. Referral to services
4. Counseling
5. Social/psychological services for people with mental health issues
6. Specialist health care
7. Child care
8. Disability services for children
9. Alcohol and substance abuse treatment
10. Parenting education
11. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

37. SER_AVAIL_IMPROVE. What are the top three support services that need improvement in terms of availability? *Choose only three.* **PROG: ALLOW UP TO THREE CHOICES.**

1. Cash benefits or other financial assistance
2. Family case management
3. Referral to services
4. Counseling
5. Social/psychological services for people with mental health issues
6. Specialist health care
7. Child care
8. Disability services for children
9. Alcohol and substance abuse treatment
10. Parenting education
11. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

38. SER_QUALITY_IMPROVE. What are the top three support services that need improvement in terms of quality (how well the service is administered)? *Choose only three.* **PROG: ALLOW ONLY UP TO THREE CHOICES.**

1. Cash benefits or other financial assistance
2. Family case management
3. Referral to services
4. Counseling
5. Social/psychological services for people with mental health issues

- 6. Specialist health care
- 7. Child care
- 8. Disability services for children
- 9. Alcohol and substance abuse treatment
- 10. Parenting education
- 11. Other, please specify _____

PROG: OPEN-ENDED FIELD

39. SER_EFFECT_IMPROVE. What are the top three support services that need improvement in terms of effectiveness (use of the service results in an improvement)? *Choose only three.* **PROG: ALLOW UP TO THREE CHOICES.**

- 1. Cash benefits or other financial assistance
- 2. Family case management
- 3. Referral to services
- 4. Counseling
- 5. Social/psychological services for people with mental health issues
- 6. Specialist health care
- 7. Child care
- 8. Disability services for children
- 9. Alcohol and substance abuse treatment
- 10. Parenting education
- 11. Other, please specify _____

PROG: OPEN-ENDED FIELD

PROG: END SECTION 2 (PLEASE COLLECT TIME STAMP)

SECTION 3: Opinions on coordination and collaboration and other service providers

ENUMERATOR: PLEASE READ OUT LOUD I will now ask you questions about your opinions of the different actors of the child care and protection system.

40. COOR_EXTENT. What is the extent of coordination and collaboration between the following actors toward meeting the needs of families?

	1 = High Coordination/ Collaboration	2 = Medium Coordination/ Collaboration	3 = Low Coordination/ Collaboration	4 = No Coordination/ Collaboration
A. Raional/local government and non-government actors				

B. National government and raional/local government actors				
C. Raional child protection actors and local actors (For example, school, police, health officies)				

41. COLLAB_WHO. With whom do you collaborate to meet the needs of families with whom you work? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. The families themselves
2. Extended family
3. Family’s neighbors
4. Community leaders (mayors, council members, other leaders)
5. Peer and colleagues in my department
6. Colleagues in other departments (such as education, health)
7. Educational institutions (schools, teachers, university, etc.)
8. Community social workers
9. Raion social work specialists
10. Services providers – child protection related
11. Services providers – non-child protection related (for example, employment or housing)
12. Law enforcement
13. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

42. PROVIDER_RATING. To what extent do you agree or disagree that you are able to call on the support of other service providers in order to provide integrated care to families?

1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

43. SER_VALUABLE. Which other service providers do you find highly valuable when you are supporting families? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Health clinics
2. Police
3. Domestic violence services

4. Schools and teachers
5. Mental health services
6. Community organizations
7. Churches
8. Other, please specify _____

PROG: OPEN-ENDED FIELD

44. SER_WEAK. Which other service providers do you find provide the weakest support? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Health clinics
2. Police
3. Domestic violence services
4. Schools and teachers
5. Mental health services
6. Community organizations
7. Churches
8. Other, please specify _____

PROG: OPEN-ENDED FIELD

45. SER_DIFF. Which other service providers do you find are the most difficult to arrange? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Health clinics
2. Police
3. Domestic violence services
4. Schools and teachers
5. Mental health services
6. Community organizations
7. Churches
8. Other, please specify _____

PROG: OPEN-ENDED FIELD

46. CIL_VIOLENCE. Do you agree or disagree that civil society (for example non-governmental organizations) is sufficiently engaged in protecting children from violence, abuse, exploitation, or neglect?

1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

47. CIL_SEPARATION. Do you agree or disagree that civil society (for example non-governmental organizations) is sufficiently engaged in preventing separation of children from families?

1. Strongly agree

2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

PROG: END SECTION 3 (PLEASE COLLECT TIME STAMP)

SECTION 4: Social worker capabilities and practices

48. RISK_FAM_VUL. What risk factors make a family more vulnerable? *Choose all that apply.*

PROG: SELECT ALL THAT APPLY.

1. Limited or lack of family income
2. Lack of adequate housing
3. Unemployment/under employment
4. Substance use/abuse
5. Conflict with the law
6. Domestic violence history
7. Mental health
8. Physical or other disabilities
9. Isolation from the community/stigmatization by other community members
10. Lack of access to services
11. Relationship within the family
12. Lack of attachments
13. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

49. RISK_FAM_PROTECT. What types of protective factors make a family more able to protect and care for their child? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Ability to meet family needs with resources available
2. Good family relationships
3. Bonding and attachment between child/children and family
4. Emotional resiliency
5. Knowledge of child development
6. Knowledge of child health and education
7. Access to basic services
8. Connection to community – other parents, neighbors, teachers, other professionals
9. Connection to extended family
10. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

50. TOOLS. Do you use a tool to assess families' ability to protect and care for their children?

1. Yes
2. No **PROG: GO TO 52. WORKLOAD**

51. ASSESS_FACTOR. **PROG: ASK IF 50. TOOLS = 1** What types of factors does that assessment look at? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Family income
2. Housing conditions
3. Family size/ Number of children
4. Age of children
5. Health issues for family members
6. Family relationship
7. Substance use/abuse
8. Domestic violence/ child abuse
9. School attendance (of children)
10. Mental health (of adults in family)
11. Family ability to meet needs with resources available
12. Family's involvement with various services
13. Family's relationships with extended family, neighbors, community
14. Caregiver knowledge of child development
15. Parenting skills and knowledge
16. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

52. WORKLOAD. How often are you in the situation where you work overtime?

1. All of the time
2. Most of the time
3. Some of the time
4. Never

53. CASE_NO. How many active cases do you currently have?

_____ **PROG: NUMBER [0-50]**

54. CONTACT_PREV_FREQ. On average, how often do you make contact with the prevention case families with whom you work?

1. Daily
2. Weekly
3. Bi-weekly
4. Monthly
5. Every other month
6. Less than every other month

55. CONTACT_ACTIVE_FREQ. On average, how often do you make contact with the active case families with whom you work?

1. Daily
2. Weekly
3. Bi-weekly
4. Monthly
5. Every other month
6. Less than every other month

56. CONTACT_MONITOR_FREQ. On average, how often do you make contact with the monitoring case families with whom you work?

1. Daily
2. Weekly
3. Bi-weekly
4. Monthly
5. Every other month
6. Less than every other month

57. CONNECT_WAYS. How do you connect with families with whom you work? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Face-to-face meetings in my office
2. Home visits
3. Telephone
4. Email
5. Meetings at the child's school
6. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

58. TIME_ASSESS. To what extent do you feel you have enough time to visit with the families you work with?

1. Always **PROG: GO TO 60. JOB_ASSESS**
2. Most of the time
3. Some of the time
4. Never

59. TIME_ASSESS_A. **PROG: ASK IF 58. TIME_ASSESS! = 1** What prevents you from having enough time? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. High case load
2. Paperwork that has to be completed
3. Family willingness to meet
4. Lack of transportation (family or worker)
5. Location of the family
6. Lack of private meeting space
7. Other, please specify _____ **PROG: OPEN-ENDED FIELD**

60. JOB_ASSESS. Do you agree or disagree with the following?

	1 = Strongly agree	2 = Somewhat agree	3 = somewhat disagree	4 = strongly disagree
A. I understand the role and responsibilities of my job				
B. I feel supported in my job				
C. My supervisor provides support that helps me to do my job better				

61. JOB RESPONSIBILITY. Which of the following are part of your job responsibilities? *Choose all that apply.* **PROG: SELECT ALL THAT APPLY.**

1. Identifying clients
2. Completing assessments
3. Interviewing / talking with clients
4. Developing care / service plans
5. Referrals to other services/organizations
6. Representing clients in court
7. Representing cases in the gatekeeping commission
8. Completing paperwork for government assistance
9. Making home visits
10. Working one-on-one with clients in my office
11. Working with adult clients
12. Working with child clients
13. Running group sessions for clients
14. Completing reports to my supervisors
15. Supervising other workers
16. Other (please specify)

PROG: BEGIN JOB RESPONSIBILITY LOOP. ASK 62. JOB RESPONSIBILITY_A FOR EACH OPTION SELECTED IN 61. JOB RESPONSIBILITY.

62. JOB RESPONSIBILITY_A. How confident do you feel in your ability to do a good job in each of the following areas of your work?

1. Very confident
2. Somewhat confident
3. Not at all confident

PROG: END JOB RESPONSIBILITY LOOP.

63. RESOURCE_FINANCE. Do you agree or disagree that you have the resources (such as office space, office supplies, transportation, financial resources for services) necessary to do your work?

1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

64. RESOURCE_PROF. Do you agree or disagree that you have the professional resources (such as supervision, training, and guides/forms) necessary to do your work?

1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

65. SER_STRENGTH. Do you agree or disagree that the services provided by social workers strengthen and stabilize families?

1. Strongly agree
2. Somewhat agree
3. Somewhat disagree
4. Strongly disagree

66. SER_STRENGTH_ACT. How effective do you find are each of the following activities undertaken by social workers to strengthen and stabilize families?

	1 = Very effective	2 = Somewhat effective	3= Not at all effective
A. Case management in general from identification to case closure			
B. Assessment in particular			
C. Case or care planning			
D. Decision-making done with the family/child			
E. Psycho-social counselling			
F. Referral to other services			

G. Monitoring visits – in office			
H. Monitoring visits – in home			
I. Direct support with financial or other materials assistance			
J. Accompany family to other services			
K. Other, specify			

67. SKILL_PROTECT. To what extent do you believe the social work workforce in your **raion/community** has the necessary skills and knowledge to adequately protect children?

- 1 Highly skilled and knowledgeable
- 2 Somewhat skilled and knowledgeable
- 3 Not at all skilled and knowledgeable

68. SKILL_SUPPORT. To what extent do you believe the social work workforce in your **raion/community** has the necessary skills and knowledge to fully support vulnerable families?

- 1 Highly skilled and knowledgeable
- 2 Somewhat skilled and knowledgeable
- 3 Not at all skilled and knowledgeable

PROG: END SECTION 4 (PLEASE COLLECT TIME STAMP)

SECTION 5: Attitudes on residential care

ENUMERATOR: PLEASE READ OUTLOUD. I will now ask you questions about residential care centers

69. TIME_RES_CARE. When might it be appropriate to place a child in a residential care facility?
Choose all that apply. **PROG: SELECT ALL THAT APPLY.**

1. When the family is poor
2. When the child is failing school
3. In cases of juvenile delinquency
4. When the community has no services to offer
5. When the child has a disability
6. When the child is an orphan
7. When the child is left behind by migrant parents
8. Never
9. Other, please specify _____

PROG: OPEN-ENDED FIELD

70. PARENTS_RES_CARE. To what extent do parents believe that residential care is acceptable for their children?

1. All parents believe it is acceptable
2. Most parents believe it is acceptable
3. Some parents believe it is acceptable
4. No parents believe it is acceptable

71. COM_RES_CARE. To what extent does the community believe residential care is a good service to care for children?

1. All community members believe it is acceptable
2. Most community members believe it is acceptable
3. Some community members believe it is acceptable
4. No community members believe it is acceptable

72. COM_DEINST. To what degree is the community supportive of deinstitutionalizing children?

1. All community members are supportive
2. Most community members are supportive
3. Some community members are supportive
4. No community members are supportive

PROG: END SECTION 5 (PLEASE COLLECT TIME STAMP)

SECTION 6: Opinions on the current wellbeing of deinstitutionalized children

73. DESINT_CHILD_ADAPT. In general, are the children who have been deinstitutionalized in your raion/community adapting well?

- 1 Mostly
- 2 Somewhat
- 3 Not at all

74. DEINST_CHILD_CHALLENGE. What, if any, are some particular challenges facing deinstitutionalized children and their caregivers? *Please select all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1 No challenges

PROG: SKIP TO 77.

WAYS_REINTEGRATE

- 2 Stigma from the community
- 3 Lack of access to school
- 4 Family risk factors (substance use, mental health issues, disability, income, etc.)
- 5 Attachment between the family and child is lacking
- 6 Access to services
- 7 Other, please specify: _____

PROG: OPEN-ENDED

75. DESINST_CHILD_CHALLENGE_A. PROG: ASK IF 74.

DEINST_CHILD_CHALLENGE!= 1. How are these challenges being addressed? *Please select all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1 With the social worker through the family care plan
- 2 Through referral to other services
- 3 Through a special education plan with the school
- 4 Counseling services for the child
- 5 Counseling services for the parents/caregiver
- 6 Counseling for the family
- 7 Disability rehabilitation or other services

- 8. Work with the community
- 9 Other, please specify: _____ **PROG: OPEN-ENDED**

76. DESINST_CHILD_CHALLENGE_B. PROG: ASK IF 74.

DEINST_CHILD_CHALLENGE!=1. Are there any categories of deinstitutionalized children who face more of the above challenges than others? *Please select all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1 Girls
- 2 Boys
- 3. Children with disabilities
- 4. Children with learning disabilities
- 5 Children with chronic illnesses
- 6 Younger children
- 7 Older children
- 8 Children who are of an ethnic minority
- 9 Children from poor families
- 10 Other, please specify: _____ **PROG: OPEN-ENDED**

77. WAYS_REINTEGRATE. In which of the following ways do you work with families of reintegrated children? *Please select all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1 Provide access to cash benefits
- 2 Provide other material assistance
- 3 Regular home visits, regular office visits
- 4 Visits to the child’s school or kindergarten
- 5 Represent the child at gatekeeping meetings
- 6 Arrange multidisciplinary meetings
- 7 Employment/household income support
- 8 Housing services
- 9 Referral to other services
- 10 Parent counseling
- 11 Parent education
- 12 Counseling for the child
- 13 Other, please specify: _____ **PROG: OPEN-ENDED**

78. DESINST_CHILD_RATE. Do you agree or disagree with the following:	1=Strongly agree	2=Somewhat agree	3=Somewhat disagree	4=Strongly disagree
A. Deinstitutionalized children’s needs are being adequately met in their family placement				
B. Deinstitutionalized children’s needs are being adequately met in their school placement				

C. Deinstitutionalized children's needs are being adequately met in the community				
D. Deinstitutionalized children's needs are being adequately met by the services available				
E. Deinstitutionalized children are in protective family care that ensures their safety and wellbeing				
F. Deinstitutionalized children are placed in well-planned placements				
G. Deinstitutionalized children are placed with their permanency in mind				
H. Deinstitutionalized children are placed with adequate consideration to their best interests				

PROG: END SECTION 6 (PLEASE COLLECT TIME STAMP)

SECTION 7: Opinions on parental skills

79. FAM_RISK_CAREGIVER. Of the families at-risk you work with, what proportion of caregivers...

Of the <u>families at-risk</u> you work with, what proportion of caregivers...	1=All	2=Most	3=Half	4=Some	5=None
A. Have positive discipline skills?(able to discipline their children without using physical punishment such as spanking or hitting)					
B. Have strong communication skills with their children					
C. Are knowledgeable about child development					
D. Are knowledgeable about child health issues					
E. Are aware of positive and negative patterns of behavior within the family?					

80. FAM_REINT_CAREGIVER. Of the families of reintegrated children you work with, what proportion of caregivers...

Of the <u>families of reintegrated children</u> you work with, what proportion of caregivers...	1=All	2=Most	3=Half	4=Some	5=None
A. Have positive discipline skills?(able to discipline their children without using physical punishment such as spanking or hitting)					
B. Have strong communication skills with their children					
C. Are knowledgeable about child development					
D. Are knowledgeable about child health issues					
E. Are aware of positive and negative patterns of behavior within the family?					

81. FAM_RISK_CAP. Of the families at risk you work with, how would you rate the change in their capacity to care for their children as a result of involvement with services?

- 1 Highly improved
- 2 Somewhat improved
- 3 A little improved
- 4 No change

82. FAM_REINT_CAP. Of the families of reintegrated children you work with, how would you rate the change in their capacity to care for their children as a result of involvement with services?

- 1 Highly improved
- 2 Somewhat improved
- 3 A little improved
- 4 No change

83. CAREGIVER_LOWSKILL. In what areas do caregivers in your community generally have lower skills and knowledge? *Please select all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1 Positive discipline skills (able to discipline their children without using physical punishment such as spanking or hitting)
- 2 Strong communication skills with their children
- 3 Knowledge of child development
- 4 Knowledge of child health issues
- 5 Awareness of positive and negative patterns of behavior within the family
- 6 Other, please specify_____

PROG: OPEN-ENDED

84. CAREGIVER_SKILL_IMPROV. How effective are each of the following methods for increasing parenting skills and knowledge for the families with whom you work?

	1 = Very effective	2 = Somewhat effective	3 = Not at all effective
A. Individual/one-on-one parenting education with a social worker			
B. Parenting classes/workshops			
C. Parent support groups			
D. Books, magazines, and other written resources			

85. METHOD_PARENT_OTHER. Is there another effective method for increasing parenting skills and knowledge we have not mentioned?

- 1 Yes
- 2 No **PROG: SKIP TO 87. POLICY_ADE**

86. METHOD_PARENT_OTHER_OE. **PROG: ASK IF 85. METHOD_PARENT_OTHER = 1.** What is this method?

_____ **PROG: OPEN-ENDED**

PROG: END SECTION 7 (PLEASE COLLECT TIME STAMP)

SECTION 8. Policies and Legislation

ENUMERATOR: PLEASE READ OUTLOUD I will now ask you question about policies and legislation.

87. POLICY_ADE. Do you agree or disagree that existing policies and legislation are being adequately implemented to support the functioning of the child protection system?

- 1 Strongly agree
- 2 Somewhat agree
- 3 Somewhat disagree
- 4 Strongly disagree

88. SYSTEM_RATE. Do you agree or disagree that the child care and protection system functions as well as it is supposed to?

- 1 Strongly agree **PROG: SKIP TO 90. CHILD_ACT**
- 2 Somewhat agree

- 3 Somewhat disagree
- 4 Strongly disagree

89. SYSTEM_RATE_A. PROG: ASK IF 88. SYSTEM_RATE !=1. What areas of the system need improvement? *Choose all that apply. Do not read out answer options; code from response.* **PROG: SELECT ALL THAT APPLY.**

- 1. National level policy and/or strategy
- 2 Raional level policy and/or strategy
- 3 Standards and guidelines for minimum package of services
- 4 Resource allocation – national level
- 5 Resource allocation – raional/local level
- 6 Workforce – adequate workforce to protect children
- 7 Workforce – adequate capacity of workforce to protect children
- 8 Coordination of actors in child protection
- 9 Collaboration between actors in child protection
- 10 Public awareness
- 11 Service development and implementation
- 12 Other, please specify: _____

PROG: OPEN-ENDED

90. CHILD_ACT. Please list one national child protection policy/legal act that is important to child protection in your raion or community. *Do not read out answer options; code from response.*

- 1 Family Code Of The Republic Of Moldova
- 2 Inter-sector cooperation mechanism for the identification, evaluation, referral, assistance and monitoring of child victims and potential child victims of violence, neglect, exploitation and trafficking
- 3 Law 140 on the Special Protection of Children at Risk and Children Separated from Parents
- 4 Law 338 on Children’s Rights
- 5 Law on Local Public Finance
- 6 The Regulation Frameworks of the organization and functioning of the district and raional social assistance entities
- 7 Regulation for the Organization and Function of Raional and Municipal Psycho-pedagogical Services
- 8 Social worker guide to case management
- 9 Service regulations (example APP, adoption, shelters)
- 10 National Strategy for Child Protection 2014-2020

91. FINANCE_RESOURCE_CHILDCARE. Are there resources in place to support the functioning of the child care and protection system?

- 1 Yes
- 2 No

PROG: SKIP TO 95. RESOURCE_PROF

92. FINANCE_RESOURCE_CHILDCARE_A. PROG: ASK IF

91.FINANCE_RESOURCE_CHILDCARE ==1. Please list the-resources available. *Choose all that apply. Do not read out answer options; code from response.* **PROG: SELECT ALL THAT APPLY.**

- 1 Financial resources for services
- 2 Financial resources for workforce hiring, training
- 3 Financial resources for workforce salaries
- 4 Office space
- 5 Technical resources (example computers, cell phones)

- 6 Transportation
- 7 Office supplies
- 8 Family contingency funds (for example to provide for specific urgent needs, such as school supplies or clothing)
- 9 Other, please specify _____ **PROG: OPEN-ENDED**

93. FINANCE_RESOURCE_CHILDCARE_B. PROG: ASK IF 91.

FINANCE_RESOURCE_CHILDCARE ==1. Are there additional resources that are not currently available?

- 1 Yes
- 2 No **PROG: SKIP TO 95. RESOURCE_PROF**

94. FINANCE_RESOURCE_CHILDCARE_C. PROG: ASK IF 93.

FINANCE_RESOURCE_CHILDCARE_B ==1. What are they? *Choose all that apply. Do not read out answer options; code from response.* **PROG: SELECT ALL THAT APPLY.**

- 1 Financial resources for services
- 2 Financial resources for workforce hiring, training
- 3 Financial resources for workforce salaries
- 4 Office space
- 5 Technical resources (example computers, cell phones)
- 6 Transportation
- 7 Office supplies
- 8 Family contingency funds (for example to provide for specific urgent needs, such as school supplies or clothing)
- 9 Other, please specify _____ **PROG: OPEN-ENDED**

95. RESOURCE_PROF. Are there professional resources (such as social work supervision or training) in place to support the functioning of the child protection system?

- a. Yes
- b. No **PROG: SKIP TO 99 CHILD_DEV_STRAT**

96. RESOURCE_PROF_A. PROG: ASK IF 95. RESOURCE_PROF ==1. Please list the professional resources available. *Choose all that apply. Do not read out answer options; code from response.* **PROG: SELECT ALL THAT APPLY.**

- 1 Social work supervision
- 2 Initial training for new social workers
- 3 Ongoing / in-service training
- 4 Working methodologies (guides and forms)
- 5 Other, please specify _____ **PROG: OPEN-ENDED**

97. RESOURCE_PROF_B. PROG: ASK IF 95. RESOURCE_PROF ==1. Are there additional resources needed that are not currently available?

- 1 Yes
- 2 No **PROG: SKIP TO 99. CHILD_DEV_STRAT**

98. RESOURCE_PROF_C. PROG: ASK IF 97. RESOURCE_PROF_B ==1. What are they? *Choose all that apply. Do not read out answer options; code from response.* **PROG: SELECT ALL THAT APPLY.**

- 1 Social work supervision
- 2 Initial training for new workers

- 3 Ongoing / in-service training
- 4 Working methodologies (guides and forms)
- 5 Other, please specify _____

PROG: OPEN-ENDED

99. CHILD_DEV_STRAT. Does your raion have a child protection service development strategy?

- 1 Yes
- 2 No

100. COUNCIL_FINANCE_CHILD. Does the raional council make financial resources available for child protection?

- 1 Yes
- 2 No

101. BUDGET_SER. To your knowledge are services for children and families included in the raional budget?

- 1 Yes
- 2 No

102. COUNCIL_SUPPORT_RATE. Do you agree or disagree that the raional council is supporting improvements in the child protection system?

- 1 Strongly agree
- 2 Somewhat agree
- 3 Somewhat disagree
- 4 Strongly disagree

103. CHILD_PROTECT_STRATE_IMPOV. What improvements in raional child protection service development strategy are needed? *Please select all that apply.* **PROG: SELECT ALL THAT APPLY.**

- 1 There is no strategy
- 2 Actors need to be more aware of the strategy
- 3 Strategy needs to be better aligned to national policy
- 4 Strategy needs to be reflect local needs and realities
- 5 Strategy should include plans for increased budget allocation
- 6 Strategy should include plans for workforce development
- 7 Strategy should include plans for development of services
- 8 Other, please specify _____

PROG: OPEN-ENDED

104. RAION_AWARE_POLICY. Do you agree or disagree that the raional council is aware of national child protection policies?

- 1 Strongly agree
- 2 Somewhat agree
- 3 Somewhat disagree
- 4 Strongly disagree

105. MAYOR_FINANCE_CHILD_PROTECT. Does the local or community government (mayor) make financial resources available for child protection?

- 1 Yes
- 2 No

I06. RAION_STR_RATE. Do you agree or disagree with the following:

	1=Strongly agree	2=Some what agree	3=Some what disagree	4=Strongly disagree
A. The raional structures in place for protecting children are effective				
B. The gatekeeping commission is effective in making best interests determinations in the placement of children				
C. The informal community structures in place for protecting children are important for helping children to be safe				
D. Family situations are too complex for me to be effective in my work				

I07. Q107: ENUMERATOR'S COMMENTS

FGD WITH CHILDREN FROM ABC GROUPS IN “OLD” DISTRICTS

Suggested number of participants per group: 6-8 children

Duration: This exercise should take around 1.5 – 2 hours. It is important that children have refreshment and opportunities to get up and move around if needed.

Note: Ethical guidance applies here. Some possible ethical considerations are attached below this FGD outline.

Required prior to the FGD: Signed parental consent forms for the child’s legal guardian and signed agreement to child protection policy from the moderator, including attending the child protection briefing.

Required for the FGD: There must be two IMAS moderators for these FGDs, one facilitating discussions and the other taking notes. The facilitator needs to be able to engage fully with the children and draw all the children out, making it essential that all notes are taken by the other team member who does not actively engage in the FGD.

Context of FGDs: The purpose of these focus group discussions is to explore the views of children who are living within communities in vulnerable families about care arrangements. The objective is to elicit their assessment of the different forms of care arrangements that exist when parental care is either impossible (e.g. parental death) or not adequate (e.g. family abuse, poverty, parental migration), identifying the strengths and challenges of different forms of family-based care, the reasons why families might opt for a child to be in residential care and whether these reasons are valid in the children’s own view, and their views on what types of support from family and outside the family are mostly likely to promote child wellbeing.

In order to create a safe space where children can feel free to share their ideas and insights, the tool will not require boys and girls to speak of their own individual experiences (although they may choose to do so). Instead its aim is to help them share with each other the experience of children more generally who live in a range of family-based care arrangements.

Tool 1: Fire fire: identifying different care arrangements

Purpose: To break the ice, then identify which different living arrangements are known to participants

Timing: 30 minutes

Key steps

1. Introduce the facilitators and ask everyone to introduce themselves – use the exercise below or an alternative ice breaker as an introduction, that the facilitator feels comfortable using:

The two facilitators introduce themselves, giving their name and using an adjective to describe themselves that begins with the same letter e.g. I am Fantastic François; I am Turbo Tharcisse; then ask all the participants to introduce themselves describing the name.

2. Fire fire: Explain that the next game will get us all to move around and have some fun, and to start to hear from you about where children live in your community.

a. Explain that the floor is on fire. People need to move around and try to keep their feet off the floor as much as possible, or they will get burnt. When you call out a number, they need to make an ‘island’ made up of that number of people (i.e. if the number called out is 3, then three people must join arms and they become an ‘island’ and can stand still because they are safe from the fire).

- b. Call out Fire Fire! Encourage them to run around, make sure that all the adults do so as well.
- c. Call out a number – e.g. Three! Depending on how many participants you have, try to choose a number that means they get into groups. When everyone is in an island of three people, ask them a question and say they must discuss the question together. First question must be something simple e.g. What was the most exciting thing that happened to me this week; What was the nicest thing that has happened to me this week.
- d. After 1-2 minutes, call out Fire fire! again. After they are moving around a bit, call out a different number. When all are in islands of that number, ask another ice-breaking question e.g. If you could be an animal, what animal would you choose to be? What would you most like to be when you grow up?
- e. After 1-2 minutes, repeat the exercise. This time, get participants into groups of 2. When they have got into pairs (one group of 3 if there is an odd number), ask: ‘Who do you live with and how many people live in your home?’
3. After they have had 1-2 minutes to talk about the question with their partner(s), go around the groups and ask everyone to say who they live with in their home. Write the answers down on some flip chart.
4. Once the answers are down, ask participants to sit back down and ask them if there are any other types of home in which children in their community are living. Add these to the list. If it has not already been mentioned, ask them about: living with one parent, both parents, extended family (who), someone in the community who is not a relative, children living as heads of household; residential care centers.

5. Discuss:

- In general, which among these options is best for children? Which is worst? Why?
- When do children usually live with their parents? Are there children who are more likely to live apart from their parents than others?

(probe: children whose parents travel for work, children whose parents have abandoned them, children living with HIV, those with disabilities, girls, boys, younger, older, etc).

Are there some groups of children who you think need a particular kind of family than others?

(probe: children living with HIV, those with disabilities, girls, boys, younger, older, etc). What are these care preferences and on what basis are they chosen (probe: long-term, short-term)?

Explain that we are now going to discuss a bit more what it is like for children who do not live with their own mother and/or father.

Tool 2: Body Map – impact of care arrangements on children’s wellbeing

Purpose: To explore children’s views about the positive and negative impact of different care arrangements on children.

Timing: 30 minutes

Options: Draw an outline of one of the participants on the ground (paper, draw in the dust) or have an outline of a body on a tablet.

Key steps

1. Draw the image (one child is asked to volunteer to lie on the sheets to have the outline of his/her body drawn in order to create the outline of a body) or introduce the drawing of a body on a tablet(s).

Key questions

2. Introduce the exercise – Ask the children to look at the different parts of the body. Explain that we want to discuss what children think, feel inside themselves, hear from others, see what is happening and do when they live in different situations. We are not asking what they feel about their own arrangement (although if they want to talk about this they can) but more in general about what children in their communities might feel.

3. Then follow the questions below starting with the community-based arrangement first mentioned by the child. Note the answers as they are discussed. Write down the key points on the paper / tablet

a. (Pointing at the head) – The head is where we take decisions. Why do children live in the different settings that they have mentioned in Exercise 1 in the community?

- Why do children move house to a different caregiver? Who usually makes the decision? Who moves the child / takes the child to the new home? Are certain 'categories' of children (ie age, gender, ability, etc) more likely to be placed in residential care? Which children are not brought to live in children's homes? Why not? Where are the families of children who live in homes?

b. (Pointing at the heart) The heart is about feeling. What are the good things about living in [the extended family – the family-based arrangement most commonly described by children]? What are the bad things?

(Probe social, emotional, cognitive, health, nutritional and personal development impacts of the care arrangement, including for different 'categories' of children).

c. (Pointing at the ear) What do you hear people say about the children who do not live with their parents? Do you agree with what is said? Why/why not?

d. (Pointing at the hands) How are children who live in [extended family care] treated? (probe issues around stigma, discrimination, safety; probe whether there are different care arrangements that make it more likely for a child to be treated well or badly?)

e. (Pointing at the mouth) Do children have a chance to express their opinion in these decisions? If so, about what? I

4. Having noted the key points about the family care arrangement, repeat with a new drawing / image on the tablet and ask about children who live in residential care or who have lived in residential care. Note, if this is an experience that none of the children find easy to imagine, skip this set of questions.

a. (Pointing at the head) – Who decides about when a child must go to residential care? Who moves the child / takes the child to the new home? Are certain 'categories' of children (ie age, gender, ability, etc) more likely to be placed in residential care? Which children are not brought to live in children's homes? Why not? Where are the families of children who live in homes?

(Probe social, emotional, cognitive, health, nutritional and personal development impacts of the care arrangement, including for different 'categories' of children).

b. (Pointing at the heart) What might be the good things about living in a residential care centre? What might be the bad things?

(Probe social, emotional, cognitive, health, nutritional and personal development impacts of the care arrangement, including for different 'categories' of children).

c. (Pointing at the ear) Do you hear anything said about the children who live in residential care centers? Do you agree with what is said? Why/why not?

d. (Pointing at the hands) Do you know how children might be treated in the care center? Do you know how they may be treated when they come back to live with their family? (probe issues around stigma,

discrimination, safety; probe whether there are different care arrangements that make it more likely for a child to be treated well or badly?

e. (Pointing at the legs/feet) Do some children leave their children's home? Why do they leave? (probe: family reunification, foster care, adoption, ageing out, run away, etc). If not all children leave the children's home, then why not? (probe: why are some children not fostered or adopted? What are the challenges or barriers to being placed in family and community-based care, as opposed to residential care?). Are there any circumstances when a child has to leave the home? (probe: aging out of care and associated preparation for leaving care, expectations, maintaining contact).

Tool 3: Support Flowers (optional, depending on time)

The purpose of this activity is to explore children's views on who they seek and gain support from, the kinds of support that they do and do not receive, and the kinds of support they wish to receive.

Key steps

1. Ask children to get in pairs or groups of three. Give each group a big piece of paper and some pencils / or a table that they can draw on. Ask them to draw the centre of a flower in the middle of the paper. In the centre, they can draw pictures of themselves and/or their families.
2. Ask children to think about the different people who provide them and/or their families with help and kindness. Give examples if necessary, ie: Who helps you when you feel sad? Who plays with you? Who helps you when you have a problem with school work? Who helps you when you have worries about the future? With whom do you share jokes? Who is kind to you? etc. Ask them to write the names/category (ie 'parent') of the person or draw a picture of each of these people in the area outside the flower. Ask them to think if there is anyone who supports their family and to consider adding that to their pictures? Ask them to draw a petal around those who give children a lot of help, to show that they are part of the flower. For those who provide less support, smaller petal can be drawn to link them into the larger flower.
3. Support children to show their drawings with the larger group and explain to the rest of the group which people provide most support to them during difficult times and the kinds of support provided.

Use this activity to enable a broader discussion on:

The characteristics of those people that are most helpful or supportive as well as the characteristics that make it harder for some people to provide support to children.

- The kind of support most sought by children
- Any kind of support that is lacking – probe on some of the practical issues that may support their caregivers or themselves to stay together in a home.
- The reasons why it can be difficult to get the desired/needed support (ie individual staff who are supportive but who cease working at the home, or someone who they would like to go to for advice in the local community but they are not allowed to leave the home to do so, etc).
- The role that children can play in supporting one another when a child has a difficulty.

Briefly tell us about the role of the ABC group – who do you work with

What do you think the important policies are that aim to protect children? What is working well with these policies? What could work better?

What is one message you have for the national government in terms of protecting children?

ETHICAL PROCEDURE FOR CONDUCTING FGDS WITH CHILDREN

The following are the key steps required for undertaking these FGDS. These issues are to be discussed during training of moderators by NORC, with P4EC support and a revised, signed version will be agreed at the training:

- All children who participate in the meetings will be informed about the purpose and content of the discussion before they arrive. All children who are invited have the right to choose not to participate.
- If children choose to participate, their legal guardian will receive a consent form, explaining the purpose of the session. They have the right to not attend, even after agreeing and their legal guardian signs the consent; a right not to participate upon arriving at the FGD; and a right to stop participating at any time during the FGD itself.
- All information in the discussion will be noted, but there will be full anonymity. Where quotations are used in any reports, identifying details will be removed, with only gender and age group information being documented in any published paper.
- There will be a script to explain the purpose and use of the research. Each participant will have this explained before agreeing to participate and at the start of the session. Legal guardians will also be read the script and asked for signed consent before children take part in the focus group discussions.
- Meetings will be held in a venue and at a time that is agreed to by caregivers and P4EC project staff as safe and suitable. Refreshments will be provided if deemed suitable.
- All FGD facilitators will have received training on, and signed, P4EC's code of conduct and NORC's Pledge of Confidentiality. If moderators have any concerns about child protection breaches, they are to speak with the social workers linked to the family.
- If the moderator has any concern regarding the emotional wellbeing of any child following the FGD, she can contact the social worker who can follow up.

Children in at-risk families 12-14 age group, single gender (4 total – 2 new, 2 old)

Children in at-risk families 15-17, single gender (4 total – 2 new, 2 old)

Suggested number of participants per group: 6-8 children

Duration: This exercise should take around 1.5 – 2 hours. It is important that children have refreshment and opportunities to get up and move around if needed.

Note: Ethical guidance applies here. Some possible ethical considerations are attached below this FGD outline.

Required prior to the FGD: Signed parental consent forms for the child's legal guardian and signed agreement to child protection policy from the moderator, including attending the child protection briefing.

Required for the FGD: There must be two IMAS moderators for these FGDs, one facilitating discussions and the other taking notes. The facilitator needs to be able to engage fully with the children and draw all the children out, making it essential that all notes are taken by the other team member who does not actively engage in the FGD.

Context of FGDs: The purpose of these focus group discussions is to explore the views of children who are living within communities in vulnerable families about care arrangements. The objective is to elicit their assessment of the different forms of care arrangements that exist when parental care is either impossible (e.g. parental death) or not adequate (e.g. family abuse, poverty, parental migration), identifying the strengths and challenges of different forms of family-based care, the reasons why families might opt for a child to be in residential care and whether these reasons are valid in the children's own view, and their views on what types of support from family and outside the family are mostly likely to promote child wellbeing.

In order to create a safe space where children can feel free to share their ideas and insights, the tool will not require boys and girls to speak of their own individual experiences (although they may choose to do so). Instead its aim is to help them share with each other the experience of children more generally who live in a range of family-based care arrangements.

Tool 1: Fire fire: identifying different care arrangements

Purpose: To break the ice, then identify which different living arrangements are known to participants

Timing: 30 minutes

Key steps

1. Introduce the facilitators and ask everyone to introduce themselves – use the exercise below or an alternative ice breaker as an introduction, that the facilitator feels comfortable using:

The two facilitators introduce themselves, giving their name and using an adjective to describe themselves that begins with the same letter e.g. I am Fantastic François; I am Turbo Tharcisse; then ask all the participants to introduce themselves describing the name.

2. Fire fire: Explain that the next game will get us all to move around and have some fun, and to start to hear from you about where children live in your community.

a. Explain that the floor is on fire. People need to move around and try to keep their feet off the floor as much as possible, or they will get burnt. When you call out a number, they need to make an 'island'

made up of that number of people (i.e. if the number called out is 3, then three people must join arms and they become an 'island' and can stand still because they are safe from the fire).

b. Call out Fire Fire! Encourage them to run around, make sure that all the adults do so as well.

c. Call out a number – e.g. Three! Depending on how many participants you have, try to choose a number that means they get into groups. When everyone is in an island of three people, ask them a question and say they must discuss the question together. First question must be something simple e.g. What was the most exciting thing that happened to me this week; What was the nicest thing that has happened to me this week.

d. After 1-2 minutes, call out Fire fire! again. After they are moving around a bit, call out a different number. When all are in islands of that number, ask another ice-breaking question e.g. If you could be an animal, what animal would you choose to be? What would you most like to be when you grow up?

e. After 1-2 minutes, repeat the exercise. This time, get participants into groups of 2. When they have got into pairs (one group of 3 if there is an odd number), ask: 'Who do you live with and how many people live in your home?'

3. After they have had 1-2 minutes to talk about the question with their partner(s), go around the groups and ask everyone to say who they live with in their home. Write the answers down on some flip chart.

4. Once the answers are down, ask participants to sit back down and ask them if there are any other types of home in which children in their community are living. Add these to the list. If it has not already been mentioned, ask them about: living with one parent, both parents, extended family (who), someone in the community who is not a relative, children living as heads of household; residential care centers.

5. Discuss:

- In general, which among these options is best for children? Which is worst? Why?

- When do children usually live with their parents? Are there children who are more likely to live apart from their parents than others?

(probe: children whose parents travel for work, children whose parents have abandoned them, children living with HIV, those with disabilities, girls, boys, younger, older, etc).

Are there some groups of children who you think need a particular kind of family than others?

(probe: children living with HIV, those with disabilities, girls, boys, younger, older, etc). What are these care preferences and on what basis are they chosen (probe: long-term, short-term)?

Explain that we are now going to discuss a bit more what it is like for children who do not live with their own mother and/or father.

Tool 2: Body Map – impact of care arrangements on children's wellbeing

Purpose: To explore children's views about the positive and negative impact of different care arrangements on children.

Timing: 30 minutes

Options: Draw an outline of one of the participants on the ground (paper, draw in the dust) or have an outline of a body on a tablet.

Key steps

1. Draw the image (one child is asked to volunteer to lie on the sheets to have the outline of his/her body drawn in order to create the outline of a body) or introduce the drawing of a body on a tablet(s).

Key questions

2. Introduce the exercise – Ask the children to look at the different parts of the body. Explain that we want to discuss what children think, feel inside themselves, hear from others, see what is happening and do when they live in different situations. We are not asking what they feel about their own arrangement (although if they want to talk about this they can) but more in general about what children in their communities might feel.

3. Then follow the questions below starting with the community-based arrangement first mentioned by the child. Note the answers as they are discussed. Write down the key points on the paper / tablet

a. (Pointing at the head) – The head is where we take decisions. Why do children live in the different settings that they have mentioned in Exercise 1 in the community?

- Why do children move house to a different caregiver? Who usually makes the decision? Who moves the child / takes the child to the new home? Are certain 'categories' of children (ie age, gender, ability, etc) more likely to be placed in residential care? Which children are not brought to live in children's homes? Why not? Where are the families of children who live in homes?

b. (Pointing at the heart) The heart is about feeling. What are the good things about living in [the extended family – the family-based arrangement most commonly described by children]? What are the bad things?

(Probe social, emotional, cognitive, health, nutritional and personal development impacts of the care arrangement, including for different 'categories' of children).

c. (Pointing at the ear) What do you hear people say about the children who do not live with their parents? Do you agree with what is said? Why/why not?

d. (Pointing at the hands) How are children who live in [extended family care] treated? (probe issues around stigma, discrimination, safety; probe whether there are different care arrangements that make it more likely for a child to be treated well or badly?)

e. (Pointing at the mouth) Do children have a chance to express their opinion in these decisions? If so, about what? I

4. Having noted the key points about the family care arrangement, repeat with a new drawing / image on the tablet and ask about children who live in residential care or who have lived in residential care. Note, if this is an experience that none of the children find easy to imagine, skip this set of questions.

a. (Pointing at the head) – Who decides about when a child must go to residential care? Who moves the child / takes the child to the new home? Are certain 'categories' of children (ie age, gender, ability, etc) more likely to be placed in residential care? Which children are not brought to live in children's homes? Why not? Where are the families of children who live in homes?

(Probe social, emotional, cognitive, health, nutritional and personal development impacts of the care arrangement, including for different 'categories' of children).

b. (Pointing at the heart) What might be the good things about living in a residential care centre? What might be the bad things?

(Probe social, emotional, cognitive, health, nutritional and personal development impacts of the care arrangement, including for different 'categories' of children).

c. (Pointing at the ear) Do you hear anything said about the children who live in residential care centers? Do you agree with what is said? Why/why not?

d. (Pointing at the hands) Do you know how children might be treated in the care center? Do you know how they may be treated when they come back to live with their family? (probe issues around stigma, discrimination, safety; probe whether there are different care arrangements that make it more likely for a child to be treated well or badly?)

e. (Pointing at the legs/feet) Do some children leave their children's home? Why do they leave? (probe: family reunification, foster care, adoption, ageing out, run away, etc). If not all children leave the children's home, then why not? (probe: why are some children not fostered or adopted? What are the challenges or barriers to being placed in family and community-based care, as opposed to residential care?). Are there any circumstances when a child has to leave the home? (probe: ageing out of care and associated preparation for leaving care, expectations, maintaining contact).

Tool 3: Support Flowers (optional, depending on time)

The purpose of this activity is to explore children's views on who they seek and gain support from, the kinds of support that they do and do not receive, and the kinds of support they wish to receive.

Key steps

1. Ask children to get in pairs or groups of three. Give each group a big piece of paper and some pencils / or a table that they can draw on. Ask them to draw the centre of a flower in the middle of the paper. In the centre, they can draw pictures of themselves and/or their families.

2. Ask children to think about the different people who provide them and/or their families with help and kindness. Give examples if necessary, ie: Who helps you when you feel sad? Who plays with you? Who helps you when you have a problem with school work? Who helps you when you have worries about the future? With whom do you share jokes? Who is kind to you? etc. Ask them to write the names/category (ie 'parent') of the person or draw a picture of each of these people in the area outside the flower. Ask them to think if there is anyone who supports their family and to consider adding that to their pictures? Ask them to draw a petal around those who give children a lot of help, to show that they are part of the flower. For those who provide less support, smaller petal can be drawn to link them into the larger flower.

3. Support children to show their drawings with the larger group and explain to the rest of the group which people provide most support to them during difficult times and the kinds of support provided.

Use this activity to enable a broader discussion on:

The characteristics of those people that are most helpful or supportive as well as the characteristics that make it harder for some people to provide support to children.

- The kind of support most sought by children
- Any kind of support that is lacking – probe on some of the practical issues that may support their caregivers or themselves to stay together in a home.
- The reasons why it can be difficult to get the desired/needed support (ie individual staff who are supportive but who cease working at the home, or someone who they would like to go to for advice in the local community but they are not allowed to leave the home to do so, etc).
- The role that children can play in supporting one another when a child has a difficulty.

ETHICAL PROCEDURE FOR CONDUCTING FGDS WITH CHILDREN

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- All information in the discussion will be noted, but there will be full anonymity. Where quotations are used in any reports, identifying details will be removed, with only gender and age group information being documented in any published paper.
- There will be a script to explain the purpose and use of the research. Each participant will have this explained before agreeing to participate and at the start of the session. Legal guardians will also be read the script and asked for signed consent before children take part in the focus group discussions.
- Meetings will be held in a venue and at a time that is agreed to by caregivers and P4EC project staff as safe and suitable. Refreshments will be provided if deemed suitable.
- All FGD facilitators will have received training on, and signed, P4EC's code of conduct and NORC's Pledge of Confidentiality. If moderators have any concerns about child protection breaches, they are to speak with the social workers linked to the family.
- If the moderator has any concern regarding the emotional wellbeing of any child following the FGD, she can contact the social worker who can follow up.

FOCUS GROUP DISCUSSIONS WITH COMMUNITY SOCIAL ASSISTANTS IN MOLDOVA

To collect before start of FGD from each participant:

- A. How many years have you been in your post as a community social assistant?
- B. How many localities do you cover?
- C. Are there other community social assistants in the same areas you are working in?
- 1. Could you please first briefly describe your work as a social assistant?

Probe: Main areas of responsibility – child protection, family support, elderly, disabled, maintenance, probation work etc.

- 2. In your communities, are there many children who cannot be looked after by their parents?
 - a. What are the reasons why children are separated from their parents?
 - b. Are the numbers of children who cannot be cared for by their parents getting larger or smaller?

Probe: Possible reasons they cannot be looked after by their parents might be because they have died or are sick, have had to move for work or, sometimes, because their own circumstances or behaviors make it hard for them to care for their children

- 3. In general, who cares for the child when biological parents cannot do so (NOTE: this is only an introduction question and you don't need to probe too much)?

Probe: Informal extended family care, foster care (APP), adoption, children are sent away.

- 4. Who makes the decision about where children will be cared for if they cannot remain in their families?
 - a. Who is involved in the decision-making?
 - b. Whose opinions are sought?

Probe: child him or herself, direct family, extended family, traditional or religious leaders, social workers

- 5. Do children do better in some types of alternative care arrangements than others?
 - a. In which types of care do they fare the best?
 - b. What are the core factors that make a care arrangement 'successful'?

Probe: type of care arrangement, age of child, gender, disability, etc

- 6. How are cases brought to your attention?
 - a. What are the main sources of referral (who brings these cases to your attention)?

Probe: Examples may be informal referrals from families or schools; families seeking assistance for care with a child; neighbors who are concerned about a child's wellbeing.

- 7. What happens to these children once their situation is brought to your attention?
 - a. What are the steps taken once a situation is brought to your attention?
 - b. Are there any formal procedures in place that are followed?
 - c. What are the roles played by the different entities involved?

Probe: Explore their understanding of role of community multi-disciplinary teams, other local entities involved, raion specialists, gatekeeping commissions, extent of referral to social worker (raion-level experts) and other sources of support for family strengthening or alternative care.

8. What are the main services for children without appropriate care(ingrijirea neadegvata) in your raion?

Probe:APP, CCTF, family support

9. Are there procedures for referral of children at risk to social work case management?
- What do you do in these cases?
 - What tools do you use?
10. What supports and services at the community level aimed at family support and strengthening exist?
- How effective are they at supporting and strengthening families?
 - Which work the best?
 - Which don't work as well?

Probe: community social assistants, multi-disciplinary team, government offices, mayor, neighbors, Community Based Organizations, churches

11. To what extent do you feel that you have sufficient authority, training, and support to meet the needs of children at risk?
- To what extent do you feel that you have everything you need to do your job well?
 - (In areas where don't feel have everything) what would help you to do this work better?

Probe: clarity of their role; clarity of responsibilities, level of workload, supervision and training, resources.

12. The national policy recommends that children do not live in residential care centers, as long as there are other family options available. Do you agree that children should ideally stay in the community?
- If so, why?
 - Is it ever appropriate for a child to be placed in a residential care center? (if yes) Please explain under what circumstances.
13. Do you think that children returning from residential care centers to their family home or to another family-based care arrangement might face challenges in the community?
- If so, what type of support to the child do you think might be most helpful?
 - Who should provide this support?
 - Are there any procedures in place for this support?
14. Do you think that caregivers or families who receive a child who has been living in a residential care center may face challenges?
- If so, what type of support to the family do you think might be most helpful?
 - Who should provide this support?
 - Are there any procedures in place for this support?
15. Based on the issues that you have discussed just now, what would you say are the most important and effective interventions that can help families care for children appropriately and reduce family separation?
- What do families need in order to care for their children?
 - What do parents need to be better parents?

Probe: community social worker and raion-level specialists role

16. If you could pick three priority actions that would make children who cannot live with their parents or families better protected, what would they be?
- a. Who should lead these actions?

FOCUS GROUP DISCUSSIONS WITH SOCIAL WORK SPECIALISTS IN MOLDOVA

To collect before start of FGD from each participant:

- D. What is your position?
- E. How many years have you been in your post?
- F. What areas do you cover (all the raion or what is the number of localities)?

1. Could you please first briefly describe your work as a social worker?

Probe: Main areas of responsibility – child protection, family support, elderly, disabled, maintenance, probation work etc.

2. In your raion, are there many children who cannot be looked after by their parents?
 - a. What are the reasons why children are separated from their parents?
 - b. Are the numbers of children who cannot be cared for by their parents getting larger or smaller?

Probe: Possible reasons they cannot be looked after by their parents might be because they have died or are sick, have had to move for work or, sometimes, because their own circumstances or behaviors make it hard for them to care for their children

3. In general, who cares for the child when biological parents cannot do so (NOTE: this is only an introduction question and you don't need to probe too much)?

Probe: Informal extended family care, foster care (APP), adoption, children are sent away.

4. Who makes the decision about where children will be cared for if they cannot remain in their families?
 - a. Who is involved in the decision-making?
 - b. Whose opinions are sought?

Probe: child him or herself, direct family, extended family, traditional or religious leaders, social workers

5. Do children do better in some types of alternative care arrangements than others?
 - a. In which types of care do they fare the best?
 - b. What are the core factors that make a care arrangement 'successful'?
 - c. In which types of care do they do less well?

Probe: type of care arrangement, age of child, gender, disability, etc

6. How are cases brought to your attention?
 - a. What are the main sources of referral (who brings these cases to your attention)?

Probe: Examples may be community social assistants, community multi-disciplinary teams, other local entities, informal referrals from other sources.

7. What happens to these children once their situation is brought to your attention?
 - a. What are the steps taken once a situation is brought to your attention?
 - b. Are there any formal procedures in place that are followed?
 - c. What are the roles played by the different entities involved?

Probe: Explore their understanding of role of community multi-disciplinary teams, other local entities involved, gatekeeping commissions, extent of referral other sources of support for family strengthening or alternative care.

8. What are the main services for children without appropriate care(ingrijirea neadegvata) in your raion?

Probe:APP, CCTF, family support

9. What supports and services at the community level aimed at family support and strengthening exist?
- How effective are they at supporting and strengthening families?
 - Which work the best?
 - Which don't work as well?

Probe: community social assistants, multi-disciplinary team, government offices, mayor, neighbors, Community Based Organizations, churches

10. To what extent do you feel that you have sufficient authority, training, and support to meet the needs of children at risk?
- To what extent do you feel that you have everything you need to do your job well?
 - (In areas where don't feel have everything) what would help you to do this work better?

Probe: clarity of their role; clarity of responsibilities, level of workload, supervision and training, resources.

11. The national policy recommends that children do not live in residential care centers, as long as there are other family options available. Do you agree that children should ideally stay in the community?
- If so, why?
 - Is it ever appropriate for a child to be placed in a residential care center? (if yes) Please explain under what circumstances.

12. Do you think that children returning from residential care centers to their family home or to another family-based care arrangement might face challenges in the community?
- If so, what type of support to the child do you think might be most helpful?
 - Who should provide this support?
 - Are there any procedures in place for this support?

13. Do you think that caregivers or families who receive a child who has been living in a residential care center may face challenges?
- If so, what type of support to the family do you think might be most helpful
 - Who should provide this support?
 - Are there any procedures in place for this support?

14. Based on the issues that you have discussed just now, what would you say are the most important and effective interventions that can help families care for children appropriately and reduce family separation?
- What do families need in order to care for their children?
 - What do parents need to be better parents?

Probe: community social worker and raion-level specialists' role

15. If you could pick three priority actions that would make children who cannot live with their parents or families better protected, what would they be?
 - a. Who should lead these actions?

FOCUS GROUP DISCUSSIONS WITH GATEKEEPING COMMISSION MEMBERS

To collect before start of FGD from each participant:

G. How many members are part of your gatekeeping commission?

H. How long have you been a part of the gatekeeping commission?

I. What is your profession?

1. Could you please first briefly describe your work as members of the Gatekeeping Commission?
 - a. What is your role?
 - b. What are your responsibilities?

Probe: areas of activity e.g. protection decisions, material support, education access, awareness raising on children's rights etc.

2. Who are the other actors you collaborate with in your work as a commission?
 - a. How would you describe the collaboration?
 - b. What are the positive aspects?
 - c. What are the negative aspects?

3. Who is involved in alternative placement decisions?

Probe: child him or herself, direct family, extended family, traditional or religious leaders, social workers

4. Under what circumstances is a child placed in a residential care center?

5. In your experience, what determines whether an alternative care arrangement is successful?
 - a. What challenges exist to a successful alternative care?

Probe: type of care arrangement, age of child, gender, disability, etc

6. To what extent do you feel that your commission has sufficient authority, training and recognition or support to meet the needs of children at risk?
 - a. What would help you to do this work better?

7. In general, what do you feel would be the ideal form of care for children who cannot live with their parents?
 - a. What are the advantages for children to living in the community as compared to within a residential care facility?
 - b. What are the advantages to living in residential care facility?

8. In your opinion, what are the strengths of the current child care and protection system?

9. In your opinion, what are the weaknesses of the current child care and protection system?

10. If you could pick three priority actions that would make families stronger in caring for their children, what would those be?

11. If you could pick three priority actions that would make children who cannot live with their parents or families better protected, what would they be?

12. Is there anything else you would like to discuss?

FOCUS GROUP DISCUSSIONS WITH MAYORS IN MOLDOVA

1. In your communities, are there many children who cannot be looked after by their parents?
 - a. What are the reasons why children are separated from their parents?
 - b. Are the numbers of children who cannot be cared for by their parents getting larger or smaller?

Probe: Possible reasons they cannot be looked after by their parents might be because they have died or are sick, have had to move for work or, sometimes, because their own circumstances or behaviors make it hard for them to care for their children

2. In general, who cares for the child when biological parents cannot do so?

Probe: Informal extended family care, foster care (APP), adoption, children are sent away.

3. Do cases of children at risk get brought to your attention?
 - a. If so, who brings them to your attention?

Probe: Examples may be informal referrals from families or schools; families seeking assistance for care with a child; neighbors who are concerned about a child's wellbeing.

4. What happens to these children once their situation is brought to your attention?

Probe: Explore understanding of role of community social assistants, community multi-disciplinary teams, other local entities involved, raion-level social workers, gatekeeping commission, and other sources of support for family strengthening or alternative care. Identify any programs providing alternative care.

5. What is your role once the situation is brought to your attention?

Probe for understanding of mayor's mandate.

6. Do children do better in some types of alternative care arrangements (when they cannot be cared for by their biological parents) than others?
 - a. In which types of care do they do the best?
 - b. In which types of care do they do less well?
 - c. Are some care arrangements better than others for children of different ages, genders or facing particular issues?

Probe: what are the core factors that make a alternative care arrangement 'successful'?

7. The national policy recommends that children do not live in residential care centers, as long as there are other family options available. Do you agree that children should ideally stay in the community?
 - a. If so, why?
 - b. Is it ever appropriate for a child to be placed in a residential care center? (if yes) Please explain under which circumstances.
8. Do you think that children returning from residential care centers to their family home or to another family-based care arrangement might face challenges in the community?
 - a. If so, what type of support to the child do you think might be most helpful?
 - b. Who should provide this support?
 - c. Are there any procedures in place for this support?

9. Do you think that caregivers or families who receive a child who has been living in a residential care center may face challenges?
 - a. If so, what type of support to the family do you think might be most helpful
 - b. Who should provide this support?
 - c. Are there any procedures in place for this support?
10. To what extent do you feel that families have the skills and knowledge they need to care for their children?
 - a. What actions do you believe would help parents and families to become better in their protection and care of children?
11. What would be three priority actions to help prevent children from being separated from their parents?
12. What would be three priority actions that would make children who cannot live with their parents or families better protected?

FOCUS GROUP DISCUSSIONS WITH MAYORS IN MOLDOVA

1. In your communities, are there many children who cannot be looked after by their parents?
 - a. What are the reasons why children are separated from their parents?
 - b. Are the numbers of children who cannot be cared for by their parents getting larger or smaller?

Probe: Possible reasons they cannot be looked after by their parents might be because they have died or are sick, have had to move for work or, sometimes, because their own circumstances or behaviors make it hard for them to care for their children

2. In general, who cares for the child when biological parents cannot do so?

Probe: Informal extended family care, foster care (APP), adoption, children are sent away.

3. Do cases of children at risk get brought to your attention?
 - a. If so, who brings them to your attention?

Probe: Examples may be informal referrals from families or schools; families seeking assistance for care with a child; neighbors who are concerned about a child's wellbeing.

4. What happens to these children once their situation is brought to your attention?

Probe: Explore understanding of role of community social assistants, community multi-disciplinary teams, other local entities involved, raion-level social workers, gatekeeping commission, and other sources of support for family strengthening or alternative care. Identify any programs providing alternative care.

5. What is your role once the situation is brought to your attention?

Probe for understanding of mayor's mandate.

6. Do children do better in some types of alternative care arrangements (when they cannot be cared for by their biological parents) than others?
 - a. In which types of care do they do the best?
 - b. In which types of care do they do less well?
 - c. Are some care arrangements better than others for children of different ages, genders or facing particular issues?

Probe: what are the core factors that make a alternative care arrangement 'successful'?

7. The national policy recommends that children do not live in residential care centers, as long as there are other family options available. Do you agree that children should ideally stay in the community?
 - a. If so, why?
 - b. Is it ever appropriate for a child to be placed in a residential care center? (if yes) Please explain under which circumstances.
8. Do you think that children returning from residential care centers to their family home or to another family-based care arrangement might face challenges in the community?
 - a. If so, what type of support to the child do you think might be most helpful?
 - b. Who should provide this support?
 - c. Are there any procedures in place for this support?

9. Do you think that caregivers or families who receive a child who has been living in a residential care center may face challenges?
 - a. If so, what type of support to the family do you think might be most helpful
 - b. Who should provide this support?
 - c. Are there any procedures in place for this support?
10. To what extent do you feel that families have the skills and knowledge they need to care for their children?
 - a. What actions do you believe would help parents and families to become better in their protection and care of children?
11. What would be three priority actions to help prevent children from being separated from their parents?
12. What would be three priority actions that would make children who cannot live with their parents or families better protected?

FOCUS GROUP DISCUSSIONS WITH MULTI-DISCIPLINARY PROFESSIONALS

*Make sure have a few teachers in each group.

To collect before start of FGD from each participant:

- J. What is your position?
- K. How many years have you worked in this post?
- L. How long have you been part of the multi-disciplinary team for child care, protection, and safety?
- 1. Could you please first briefly describe your work in the community?
 - a. What are your main areas of responsibility?
- 2. What is your work related to child care, protection and safety?
 - a. What do you do beyond your activities as a member of the multi-disciplinary team?
- 3. In your communities, are there many children who cannot be looked after by their parents?
 - a. What are the reasons why children are separated from their parents?
 - b. Are the numbers of children who cannot be cared for by their parents getting larger or smaller?

Probe: Possible reasons they cannot be looked after by their parents might be because they have died or are sick, have had to move for work or, sometimes, because their own circumstances or behaviors make it hard for them to care for their children

- 4. In general, who cares for the child when biological parents cannot do so (NOTE: this is only an introduction question and you don't need to probe too much)?

Probe: Informal extended family care, foster care (APP), adoption, children are sent away.

- 5. Who makes the decision about where children will be cared for if they cannot remain in their families?
 - a. Who is involved in the decision-making?
 - b. Whose opinions are sought?

Probe: child him or herself, direct family, extended family, traditional or religious leaders, social workers

- 6. Do children do better in some types of alternative care arrangements than others?
 - a. In which types of care do they fare the best?
 - b. What are the core factors that make a care arrangement 'successful'?
 - c. In which types of care do they do less well?

Probe: type of care arrangement, age of child, gender, disability, etc

- 7. Do cases of children at risk get brought to your attention?
 - a. If so, who brings them to your attention?

Probe: Examples may be community social assistants; informal referrals from families or schools; families seeking assistance for care with a child; neighbors who are concerned about a child's wellbeing.

- 8. What happens to these children once their situation is brought to your attention?
 - a. What are the steps taken once a situation is brought to your attention?
 - b. Are there any formal procedures in place that are followed?
 - c. What are the roles played by the different entities involved?

Probe: Explore their understanding of inter-agency cooperation, other local entities involved, community social workers, raion specialists, gatekeeping commissions, extent of referral to social worker (raion-level experts) and other sources of support for family strengthening or alternative care.

9. What supports and services at the community level aimed at family support and strengthening exist?
 - a. How effective are they at supporting and strengthening families?
 - b. Which work the best?
 - c. Which don't work as well?

Probe: community social assistants, multi-disciplinary team, government offices, mayor, neighbors, Community Based Organizations, churches

10. To what extent do you feel that you have sufficient authority, training, and support to meet the needs of vulnerable children?
 - a. To what extent do you feel that you have everything you need to do your job well?
 - b. (In areas where don't feel have everything) what would help you to do this work better?

Probe: clarity of their role; clarity of responsibilities, level of workload, supervision and training, resources.

11. The national policy recommends that children do not live in residential care centers, as long as there are other family options available. Do you agree that children should ideally stay in the community?
 - a. If so, why?
 - b. Is it ever appropriate for a child to be placed in a residential care center? (if yes) Please explain under what circumstances.
12. Do you think that children returning from residential care centers to their family home or to another family-based care arrangement might face challenges in the community?
 - a. If so, what type of support to the child do you think might be most helpful?
 - b. Who should provide this support?
13. Do you think that caregivers or families who receive a child who has been living in a residential care center may face challenges?
 - a. If so, what type of support to the family do you think might be most helpful?
 - b. Who should provide this support?
14. To what extent do you feel that families have the skills and knowledge they need to care for their children?
 - a. What do you think families need in order to be able to care for their children?
 - b. What do parents need to be better parents?

Probe: community social worker and raion-level specialists role

15. What would be three priority actions to help prevent children from being separated from their parents?
 - a. Who should lead these actions?

16. What would be three priority actions that would make children who cannot live with their parents or families better protected?
 - a. Who should lead these actions?

FOCUS GROUP DISCUSSIONS WITH PARENTS MOLDOVA

6 FGD: 3 in “old” and 3 in “new” districts

Types of groups: parents of children at risk of separation, parents of post institutionalized children, parents of children currently in institutions

1. What are some of the challenges that families in Moldova face in general that affects their ability to care for their children?
2. What kinds of support help families to be strong in caring for children?
 - a. How does this support help them?
 - b. Who provides or should provide it?
 - c. How easy is it to access this support?
 - d. What is your opinion of the quality of this support?
 - e. How effective is this support (provide examples)?

Probe: community support, extended family, service provision or facilitating access? Identify child-focused and family-focused interventions

3. What kinds of skills, information or knowledge do families need to be good caregivers to their children?
 - a. Why is this skill/information/knowledge important?
 - b. Who can help parents obtain these skills/information/knowledge if they don't already have it?
4. From your own experience, and also your knowledge of others in the community, who is involved in making decisions about children who cannot, for whatever reason, be looked after by their parents?
 - a. When and how does the child get involved in discussions?
 - b. Who else is involved (direct family, extended family, mayor or community leaders, social workers).
 - c. Are there any differences for different age/gender/disability, etc, of children
5. In general, what do you feel would be the ideal form of care for children who cannot live with their parents?
 - a. Can you give examples of where children are living with others and it is working really well?
 - b. What has made it work well?
 - c. Are there examples of least favorite options?
 - d. What makes this so and when and why do you think this happens?
 - e. Different perspectives on care – what are the reasons for different views e.g. type of child, type of family?
6. The national policy recommends that children do not live in residential care centers, as long as there are other family options available. Have you heard of this policy?
 - a. What are your opinions of this policy?
7. How easy is it for children returning from residential care centers to their family home or to another family member to reintegrate into the community?
 - a. What challenges are faced by these children and their caregivers?
 - b. How can you know whether a child is doing well or not?

- c. Are there some children that do better than others? (probe: boys/girls, disabled, ages)
- 8. In these situations when a child returns home, what kind of support to the caregiving family is needed?
 - a. Who should provide this support?
- 9. If you could give one message to the people responsible for making sure that all children in Moldova are protected, about supporting the caregivers of vulnerable children, what would it be?

Thank you

KII PROTOCOL AND QUESTIONS FOR STAKEHOLDERS AT NATIONAL LEVEL

Key Ministries: Ministry of Labor, Social Protection and Family, Ministry of Education, Ministry of Health, Ministry of Finance

Key National Partner Organizations: Terre des Hommes (implementing partner), Lumos Foundation (implementing partner), UNICEF – Child Protection Manager (not implementing partner, but key government partner), Chisinau State University, Department of Social Work (not implementing partner)

National Working Groups:

National Project Steering Committee

A. Introduction

NORC at the University of Chicago has been contracted by USAID and the Displaced Children and Orphans Fund (DCOF) to conduct an external evaluation of Partnership for Every Child’s “Children in Moldova are Cared for in Safe and Secure Families.”

NORC will be collecting information on the project at three points in time. In my interview with you today, I would like to ask you a series of questions about the child protection policy context and system for care and protection of children at-risk and/or in need of protection. The discussion should take at most 40 minutes to an hour; so we will try to be focused and brief, while still covering the key points. The information you provide will help P4EC and USAID/DCOF to improve their program.

Your identity will be kept confidential and responses indicated only at the organizational level in our reporting to USAID/DCOF.

This study is funded by the US Agency for International Development, Learning, Evaluation and Research Department. Your participation in this interview is voluntary. You may refuse to participate or may discontinue your participation at any time without penalty.

As we have only a limited time to speak today, I may contact you after our meeting with a few follow-up questions if needed? We will also contact you again for the midline and final evaluation of the project over the next few years.

I would like to record our interview today as I want to be able to make sure I capture everything you are saying and accurately reflect your opinions. The recording will be destroyed at the end of the study period. Do you agree to being recorded? May I begin the interview?

[IF YES, TURN ON THE RECORDER ON THE TABLET, OBTAIN RECORDED CONSENT AND CONTINUE WITH QUESTIONS]

(Repeat for the recording) Do you agree to being recorded?

B. Context (*gathering core information about role of the KI in supporting family strengthening*)

- I. We are interviewing stakeholders at national level who are involved in protection and care of children without parental care and/or those at-risk of losing family care, including children being deinstitutionalized from Moldova’s institutions. Could you please describe your own role within the department/agency/organization in relation to such children?

C. Policy context

(Questions relate to Evaluation Question 4(a) *Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote appropriate family care for children without parental care?* and 3(a) *Are children at risk of losing family care continuing to live in appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?*)

2. Could you please describe the key national child protection policies in Moldova?
 - a. What are the key elements of this policy?
 - b. Why are these key elements important?
 - c. If you are not aware of the national policies, would you like to be kept informed about these policies? How could this information best be shared with you?
3. What is your (ministry/organization) role in supporting the implementation of these policies?
4. Do you know / think that the Government regulations are in line with the UNCRC and International Guidelines for Alternative Care? If not, what in your view needs to happen to bring them into alignment?
5. Within your (ministry/organization), what is the policy (if there is one) or position on residential care facilities/institutionalization for children in need of protection?
 - a. Are there divergent views within the ministry/organization on institutionalization and deinstitutionalization
 - b. (If answer to a is yes) What is your view of the residential care facility policy/position for children in need of protection?
6. How well do you feel that the current national (and organizational, for non-government informants) policies on child protection are acting to support families to care for their children and prevent child separation from parents?
 - a. Are you aware of policies or programs that support children to remain in family-based care, with their biological families, extended families or foster families?
 - b. If yes, do you feel that the P4EC program (to your knowledge) is aligned with these policies and programs?
7. Are you aware of the National Strategy for Child Protection 2014-2020?
 - a. What is your view of the extent to which it is being implemented?
 - b. What do you consider to be the main successes and challenges in ensuring its implementation?
8. What is your view on why children are currently placed in residential care facilities? (Probe for issues related to age, gender, social and economic family factors, physical or other health issues, etc.)
 - a. What is your view on factors preventing children currently living in residential care facilities from being placed in permanent family care?
9. In your opinion what facilitates family-based care?

D. Capacity to deliver alternative care programs

(Questions relate to Evaluation Question 5(a): *Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?!*)

10. How do you (where relevant to implementation of alternative care) currently track / work with your government counterparts at local, provincial or national level to track the number of children living in residential care facilities, alternative care, and families with vulnerable children that are at risk of separation? Are you aware of a national Child Protection Management Information System?
11. What, if any training, have you received in delivery of alternative care programs? And who has provided this training? (Probe: phases of care: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)
12. Are there additional information, knowledge or skills that would assist you to undertake your own role within your organization/department/agency? (Probe for phases of reintegration: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)
13. Can you please describe your understanding of how children's individual circumstances are currently being managed through a case management system?
 - a. From your perspective, do you think that this system is working well or not working?
 - b. What are the main challenges and successes?

E. Coordination and collaboration

Questions relate to Evaluation Question 5 (b) *Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?*

14. From your perspective, who are the key actors at the sub-national level whose responsibility it is to protect children? [Probe to get information on all sub-national players – commune, municipal, district, etc.]
 - a. Why are these the most important actors? [Probe for mandate, capacity]
 - b. What are the main challenges that these actors are facing? What are their main achievements?
15. Does your (ministry/organization) collaborate with other (ministries/organizations)? In what ways?
 - a. How would you characterize the collaboration?
16. Does your (ministry/organization) collaborate with state or non-state service providers or other actors involved in protecting children at the local level?
 - a. How would you characterize the collaboration?

E. Models and approaches for expansion, adaptation

(Refers to Evaluation Question 6: *Did the project offer models and approaches for expansion, adaptation, and/or replication?*)

17. How does your (ministry/organization) plan to share the lessons learned from this project's implementation? **[May not be appropriate to ask at this time, skip if no time]**
18. Do you feel that sharing is important? Why or why not? **[May not be appropriate to ask at this time, skip if no time]**
19. Are there practices, techniques or strategies that you expect will be particularly successful? Why?
20. What is your view on the work being done by P4EC in Moldova and the need for such a program?
 - a. In what area are they making a major contribution?
 - b. In what areas could they improve?

KII PROTOCOL AND QUESTIONS FOR RCC DIRECTORS

A. Introduction

NORC at the University of Chicago has been contracted by USAID and the Displaced Children and Orphans Fund (DCOF) to conduct an external evaluation of Partnership for Every Child's "Children in Moldova are Cared for in Safe and Secure Families."

NORC will be collecting information on the project at three points in time. In my interview with you today, I would like to ask you a series of questions about the child protection policy context and system for care and protection of children at-risk and/or in need of protection. The discussion should take at most 40 minutes to an hour; so we will try to be focused and brief, while still covering the key points. The information you provide will help P4EC and USAID/DCOF to improve their program.

Your identity will be kept confidential and responses indicated only at the organizational level in our reporting to USAID/DCOF.

This study is funded by the US Agency for International Development, Learning, Evaluation and Research Department. Your participation in this interview is voluntary. You may refuse to participate or may discontinue your participation at any time without penalty.

As we have only a limited time to speak today, I may contact you after our meeting with a few follow-up questions if needed? We will also contact you again for the midline and final evaluation of the project over the next few years.

I would like to record our interview today as I want to be able to make sure I capture everything you are saying and accurately reflect your opinions. The recording will be destroyed at the end of the study period. Do you agree to being recorded? May I begin the interview?

[IF YES, TURN ON THE RECORDER ON THE TABLET, OBTAIN RECORDED CONSENT AND CONTINUE WITH QUESTIONS]

(Repeat for the recording) Do you agree to being recorded?

B. Context (*gathering core information about role of the KI in supporting family strengthening*)

1. We are interviewing stakeholders at regional level who are involved in protection and care of children without parental care and/or those at-risk of losing family care, including children being deinstitutionalized from Moldova's institutions. Could you please describe your own role within the department/agency/organization in relation to such children?

C. Policy context

(Questions relate to Evaluation Question 4(a) *Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote appropriate family care for children without parental care?* and 3(c) *Are children at risk of losing family care continuing to live in appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?*)

2. Could you please describe the key national child protection policies in Moldova?
 - d. What are the key elements of this policy?
 - e. Why are these key elements important?
 - f. If you are not aware of the national policies, would you like to be kept informed about these policies? How could this information best be shared with you?
3. What is your role in supporting the implementation of these policies?

4. Within your center what is the policy or position on residential care facilities/institutionalization for children in need of protection?
 - a. Are there divergent views within the department on institutionalization and deinstitutionalization
 - b. (If answer to a is yes) What is your view of the residential care facility policy/position for children in need of protection?

5. How well do you feel that the current national policies on child protection are acting to support families to care for their children and prevent child separation from parents?
 - a. Are you aware of policies or programs that support children to remain in family-based care, with their biological families, extended families or foster families?
 - b. If yes, do you feel that the P4EC program (to your knowledge) is aligned with these policies and programs?
 - c. Is there such a policy or strategy at the local level?

6. Are you aware of the National Strategy for Child Protection 2014-2020?
 - a. What is your view of the extent to which it is being implemented?
 - b. What do you consider to be the main successes and challenges in ensuring its implementation?

D. Deinstitutionalization / Separation

Questions relate to I(c) *What factors prevented placement of children in residential care into permanent family care?* I(d) *What type of social service follow-up is provided to deinstitutionalized children, by whom and for how long?*

7. What is your view on why children are currently placed in care outside of their family? (Probe for issues related to age, gender, social and economic family factors, physical or other health issues, etc.)

8. What is your view on factors preventing children currently living in residential care facilities from being placed in permanent family care?

9. In your opinion what facilitates family-based care?
10. What follow up is provided to children leaving institutions? Who provides it? For how long?
 - a. In your opinion is this follow up effective? Why or why not?
11. What factors make children at risk for separation from their families?
12. In your opinion, what skills and knowledge do caregivers need to be able to provide good care and protection for their children?
 - a. Do caregivers in your district have these skills and knowledge?
 - b. What other skills do they need and who can help them obtain these skills?

F. Capacity

(Questions relate to Evaluation Question 5(a): *Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?*)

13. What are the main challenges that the district social work staff are facing?
 - a. What are their main achievements? Probe: what is the average case load of social workers? About how long do child welfare staff stay in the job (retention rate)?

14. Please describe your understanding in case management of children in need of protection.
 - a. Who are the key actors in implementing this case management system?
 - b. Can you please describe the current state of the system in terms of successfully managing cases?
 - c. What are the main factors in key successes and challenges? [Probe for numbers of children enrolled etc.]
15. What, if any training, have you received in delivery of alternative care programs? And who has provided this training? (Probe: phases of care: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)
16. Are there additional information, knowledge or skills that would assist you to undertake your own role within your organization/department/agency? (Probe for phases of reintegration: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)

E. Coordination and collaboration

Questions relate to Evaluation Question 5 (b) *Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?*

17. From your perspective, who are the key actors at the sub-national level whose responsibility it is to protect children? [Probe to get information on all sub-national players – commune, municipal, district, etc.]
 - a. Why are these the most important actors? [Probe for mandate, capacity]
 - b. What are the main challenges that these actors are facing? What are their main achievements?
18. Does your center collaborate with other departments or state services? In what ways?
 - a. How would you characterize the collaboration?
19. Does your center collaborate with state or non-state service providers or other actors involved in protecting children at the local level?
 - a. How would you characterize the collaboration?
20. What is your view on the work being done by P4EC in Moldova and the need for such a program?
 - a. In what area are they making a major contribution?
 - b. In what areas could they improve?

KII PROTOCOL AND QUESTIONS FOR STAKEHOLDERS AT REGIONAL LEVEL

- Head of Social Assistance and Family Protection Department, District
- Head Specialist for Family and Child Protection
- Social Work Supervisor for Community Social Work
- Head of Education Department, District

A. Introduction

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Your identity will be kept confidential and responses indicated only at the organizational level in our reporting to USAID/DCOF.

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[IF YES, TURN ON THE RECORDER ON THE TABLET, OBTAIN RECORDED CONSENT AND CONTINUE WITH QUESTIONS]

(Repeat for the recording) Do you agree to being recorded?

B. Context (*gathering core information about role of the KI in supporting family strengthening*)

21. We are interviewing stakeholders at regional level who are involved in protection and care of children without parental care and/or those at-risk of losing family care, including children being deinstitutionalized from Moldova's institutions. Could you please describe your own role within the department/agency/organization in relation to such children?

C. Policy context

(Questions relate to Evaluation Question 4(a) *Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote appropriate family care for children without parental care?* and 3(c) *Are children at risk of losing family care continuing to live in*

appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?)

22. Could you please describe the key national child protection policies in Moldova?
 - g. What are the key elements of this policy?
 - h. Why are these key elements important?
 - i. If you are not aware of the national policies, would you like to be kept informed about these policies? How could this information best be shared with you?
23. What is your role in supporting the implementation of these policies?
24. Does the district have a child protection or service development strategy?
 - a. What are the key elements of this policy?
 - b. Why are these key elements important?
25. Within your department what is the policy or position on residential care facilities/institutionalization for children in need of protection?
 - a. Are there divergent views within the department on institutionalization and deinstitutionalization
 - b. (If answer to b is yes) What is your view of the residential care facility policy/position for children in need of protection?
26. How well do you feel that the current national policies on child protection are acting to support families to care for their children and prevent child separation from parents?
 - a. Are you aware of policies or programs that support children to remain in family-based care, with their biological families, extended families or foster families?
 - b. If yes, do you feel that the P4EC program (to your knowledge) is aligned with these policies and programs?
 - c. Is there such a policy or strategy at the local level?
27. Are you aware of the National Strategy for Child Protection 2014-2020?
 - a. What is your view of the extent to which it is being implemented?
 - b. What do you consider to be the main successes and challenges in ensuring its implementation?

D. Deinstitutionalization / Separation

Questions relate to 1(c) What factors prevented placement of children in residential care into permanent family care? 1(d) What type of social service follow-up is provided to deinstitutionalized children, by whom and for how long? 2(a) Did the project provide a core package of services to help ensure that residential care is prevented when possible and that reunified and deinstitutionalized children and at-risk children remain in family care?

28. What is your view on why children are currently placed in care outside of their family? (Probe for issues related to age, gender, social and economic family factors, physical or other health issues, etc.)
29. What is your view on factors preventing children currently living in residential care facilities from being placed in permanent family care?
30. In your opinion what facilitates family-based care?
31. What follow up is provided to children leaving institutions? Who provides it? For how long
 - a. In your opinion is this follow up effective? Why or why not?

E. Prevention / Family Strengthening

(Questions relate to Evaluation Question 2(c) *Have there been other unanticipated positive or negative results of the program?* 3(a) *Are households with children at risk of family separation stabilized and strengthened?* 3(b) *Were the relevant families chosen for inclusion in the project?*)

32. What factors make children at risk for separation from their families?
33. What services or supports are provided to households with children at-risk of family separation?
 - a. Which are the most effective? Why?
34. In your opinion, what skills and knowledge do caregivers need to be able to provide good care and protection for their children?
 - a. Do caregivers in your district have these skills and knowledge?
 - b. What other skills do they need and who can help them obtain these skills?

F. Capacity

(Questions relate to Evaluation Question 5(a): *Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?*)

35. What are the main challenges that the district social work staff are facing?
 - a. What are their main achievements? Probe: what is the average case load of social workers? About how long do child welfare staff stay in the job (retention rate)?
36. **[For KIs directly responsible for case management]** Please describe your role in case management of children in need of protection.
 - a. Who are the key actors in implementing this case management system?
 - b. Can you please describe the current state of the system in terms of successfully managing cases?
 - c. What are the main factors in key successes and challenges? [Probe for numbers of children enrolled etc.]
37. What, if any training, have you received in delivery of alternative care programs? And who has provided this training? (Probe: phases of care: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)
38. Are there additional information, knowledge or skills that would assist you to undertake your own role within your organization/department/agency? (Probe for phases of reintegration: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)

G. Coordination and collaboration

Questions relate to Evaluation Question 5 (b) *Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?*

39. From your perspective, who are the key actors at the sub-national level whose responsibility it is to protect children? [Probe to get information on all sub-national players – commune, municipal, district, etc.]
 - a. Why are these the most important actors? [Probe for mandate, capacity]
 - b. What are the main challenges that these actors are facing? What are their main achievements?
40. Does your department collaborate with other departments? In what ways?
 - a. How would you characterize the collaboration?
41. Does your department collaborate with state or non-state service providers or other actors involved in protecting children at the local level?
 - a. How would you characterize the collaboration?

H. Models and approaches for expansion, adaptation

(Refers to Evaluation Question 6(b) *Were any best practices or successful techniques institutionalized?*)

42. Are there practices, techniques or strategies that you expect will be particularly successful? Why?

43. What is your view on the work being done by P4EC in Moldova and the need for such a program?

- a. In what area are they making a major contribution?
- b. In what areas could they improve?

KII PROTOCOL AND QUESTIONS FOR P4EC STAFF

A. Introduction

As you know, NORC at the University of Chicago has been contracted by USAID and the Displaced Children and Orphans Fund (DCOF) to conduct an external evaluation of the “Children in Moldova are Cared for in Safe and Secure Families” Project.

NORC will be collecting information on the project at three points in time. In my interview with you today, I would like to ask you a series of questions about the child protection policy context and system for care and protection of children at-risk and/or in need of protection. The discussion should take at most 40 minutes to an hour; so we will try to be focused and brief, while still covering the key points.

Your identity will be kept confidential and responses indicated only at the organizational level in our reporting to USAID/DCOF.

This study is funded by the US Agency for International Development, Learning, Evaluation and Research Department. Your participation in this interview is voluntary. You may refuse to participate or may discontinue your participation at any time without penalty.

As we have only a limited time to speak today, I may contact you after our meeting with a few follow-up questions if needed? We will also contact you again for the midline and final evaluation of the project over the next few years.

I would like to record our interview today as I want to be able to make sure I capture everything you are saying and accurately reflect your opinions. The recording will be destroyed at the end of the study period. Do you agree to being recorded? May I begin the interview?

[IF YES, TURN ON THE RECORDER ON THE TABLET, OBTAIN RECORDED CONSENT AND CONTINUE WITH QUESTIONS]

(Repeat for the recording) Do you agree to being recorded?

B. Context (*gathering core information about role of the KI in supporting family strengthening*)

44. We are interviewing stakeholders who are involved in protection and care of children without parental care and/or those at-risk of losing family care, including children being deinstitutionalized from Moldova’s institutions. Could you please describe your own role within the organization in relation to such children?

C. Policy context

(Questions relate to Evaluation Question 4(a) *Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote appropriate family care for children without parental care?* and 3(c) *Are children at risk of losing family care continuing to live in appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?*)

1. Could you please describe the key national child protection policies in Moldova?
 - j. What are the key elements of this policy?
 - k. Why are these key elements important?
 - l. If you are not aware of the national policies, would you like to be kept informed about these policies? How could this information best be shared with you?
2. What is your role in supporting the implementation of these policies?

3. Do you know / think that the Government regulations are in line with the UNCRC and International Guidelines for Alternative Care? If not, what in your view needs to happen to bring them into alignment?
4. How well do you feel that the current national policies on child protection are acting to support families to care for their children and prevent child separation from parents?
 - a. Are you aware of policies or programs that support children to remain in family-based care, with their biological families, extended families or foster families?
 - b. If yes, do you feel that the P4EC program (to your knowledge) is aligned with these policies and programs?
5. Are you aware of the National Strategy for Child Protection 2014-2020?
 - a. What is your view of the extent to which it is being implemented?
 - b. What do you consider to be the main successes and challenges in ensuring its implementation?

D. Deinstitutionalization / Separation

Questions relate to 1(c) *What factors prevented placement of children in residential care into permanent family care?* 1(d) *What type of social service follow-up is provided to deinstitutionalized children, by whom and for how long?* 2(a) *Did the project provide a core package of services to help ensure that residential care is prevented when possible and that reunified and deinstitutionalized children and at-risk children remain in family care?*

6. What is your view on why children are currently placed in care outside of their family? (Probe for issues related to age, gender, social and economic family factors, physical or other health issues, etc.)
7. What is your view on factors preventing children currently living in residential care facilities from being placed in permanent family care?
8. In your opinion what facilitates family-based care?
9. What follow up is provided to children leaving institutions? Who provides it? For how long?
 - a. In your opinion is this follow up effective? Why or why not?

E. Prevention / Family Strengthening

(Questions relate to Evaluation Question 2(c) *Have there been other unanticipated positive or negative results of the program?* 3(a) *Are households with children at risk of family separation stabilized and strengthened?* 3(b) *Were the relevant families chosen for inclusion in the project?)*

10. What factors make children at risk for separation from their families?
11. What services or supports are provided to households with children at-risk of family separation?
 - a. Which are the most effective? Why?
12. In your opinion, what skills and knowledge do caregivers need to be able to provide good care and protection for their children?
 - a. Do caregivers in your district have these skills and knowledge?
 - b. What other skills do they need and who can help them obtain these skills?

F. Capacity

(Questions relate to Evaluation Question 5(a): *Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?)*

13. What are the main challenges that the district social work staff are facing?
 - a. What are their main achievements? Probe: what is the average case load of social workers? About how long do child welfare staff stay in the job (retention rate)?
14. How do you (where relevant to implementation of alternative care) currently track / work with your government counterparts at local, provincial or national level to track the number of children living in

residential care facilities, alternative care, and families with vulnerable children that are at risk of separation? Are you aware of a national Child Protection Management Information System?

15. Can you please describe your understanding of how children's individual circumstances are currently being managed through a case management system?
 - a. From your perspective, do you think that this system is working well or not working?
 - b. What are the main challenges and successes?
16. Are there additional information, knowledge or skills that would assist you to undertake your own role within your organization/department/agency? (Probe for phases of reintegration: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)

G. Coordination and collaboration

Questions relate to Evaluation Question 5 (b) *Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?*

17. From your perspective, who are the key actors at the sub-national level whose responsibility it is to protect children? [Probe to get information on all sub-national players – commune, municipal, district, etc.]
 - a. Why are these the most important actors? [Probe for mandate, capacity]
 - b. What are the main challenges that these actors are facing? What are their main achievements?
18. Does your organization collaborate with other government and non-government at the national level? In what ways?
 - a. How would you characterize the collaboration?
19. Does your organization collaborate with state or non-state service providers or other actors involved in protecting children at the national level? local level?
 - a. How would you characterize the collaboration?

H. Models and approaches for expansion, adaptation

(Refers to Evaluation Question 6(a) *Were lessons learned widely discussed and disseminated during project implementation?* 6(b) *Were any best practices or successful techniques institutionalized?*)

20. How does P4EC plan to share the lessons learned from this project's implementation? [**May not be appropriate to ask at this time, skip if no time**]
21. Do you feel that sharing is important? Why or why not? [**May not be appropriate to ask at this time, skip if no time**]
22. Are there practices, techniques or strategies that you expect will be particularly successful? Why?
23. What is your view on the work being done by P4EC in Moldova and the need for such a program?
 - a. In what area are you making a major contribution?
 - b. In what areas could you further improve?

KII PROTOCOL AND QUESTIONS FOR STAKEHOLDERS AT REGIONAL LEVEL

- Head of Social Assistance and Family Protection Department, District
- Head Specialist for Family and Child Protection
- Social Work Supervisor for Community Social Work
- Head of Education Department, District

A. Introduction

NORC at the University of Chicago has been contracted by USAID and the Displaced Children and Orphans Fund (DCOF) to conduct an external evaluation of Partnership for Every Child's "Children in Moldova are Cared for in Safe and Secure Families."

NORC will be collecting information on the project at three points in time. In my interview with you today, I would like to ask you a series of questions about the child protection policy context and system for care and protection of children at-risk and/or in need of protection. The discussion should take at most 40 minutes to an hour; so we will try to be focused and brief, while still covering the key points. The information you provide will help P4EC and USAID/DCOF to improve their program.

Your identity will be kept confidential and responses indicated only at the organizational level in our reporting to USAID/DCOF.

This study is funded by the US Agency for International Development, Learning, Evaluation and Research Department. Your participation in this interview is voluntary. You may refuse to participate or may discontinue your participation at any time without penalty.

As we have only a limited time to speak today, I may contact you after our meeting with a few follow-up questions if needed? We will also contact you again for the midline and final evaluation of the project over the next few years.

I would like to record our interview today as I want to be able to make sure I capture everything you are saying and accurately reflect your opinions. The recording will be destroyed at the end of the study period. Do you agree to being recorded? May I begin the interview?

[IF YES, TURN ON THE RECORDER ON THE TABLET, OBTAIN RECORDED CONSENT AND CONTINUE WITH QUESTIONS]

(Repeat for the recording) Do you agree to being recorded?

B. Context (*gathering core information about role of the KI in supporting family strengthening*)

1. We are interviewing stakeholders at regional level who are involved in protection and care of children without parental care and/or those at-risk of losing family care, including children being deinstitutionalized from Moldova's institutions. Could you please describe your own role within the department/agency/organization in relation to such children?

C. Policy context

(Questions relate to Evaluation Question 4(a) *Do professional and public attitudes show increased knowledge of and increased support of national policies that prevent unnecessary family-child separation; and promote appropriate family care for children without parental care?* and 3(c) *Are children at risk of losing family care continuing to live in appropriate, permanent and protective family care due to improved national policies and local child welfare human resource capacities and service delivery?*)

2. Could you please describe the key national child protection policies in Moldova?
m. What are the key elements of this policy?

- n. Why are these key elements important?
 - o. If you are not aware of the national policies, would you like to be kept informed about these policies? How could this information best be shared with you?
3. What is your role in supporting the implementation of these policies?
 4. Does the district have a child protection or service development strategy?
 - c. What are the key elements of this policy?
 - d. Why are these key elements important?
 5. Within your department what is the policy or position on residential care facilities/institutionalization for children in need of protection?
 - a. Are there divergent views within the department on institutionalization and deinstitutionalization
 - b. (If answer to b is yes) What is your view of the residential care facility policy/position for children in need of protection?
 6. How well do you feel that the current national policies on child protection are acting to support families to care for their children and prevent child separation from parents?
 - a. Are you aware of policies or programs that support children to remain in family-based care, with their biological families, extended families or foster families?
 - b. If yes, do you feel that the P4EC program (to your knowledge) is aligned with these policies and programs?
 - c. Is there such a policy or strategy at the local level?
 7. Are you aware of the National Strategy for Child Protection 2014-2020?
 - a. What is your view of the extent to which it is being implemented?
 - b. What do you consider to be the main successes and challenges in ensuring its implementation?

D. Deinstitutionalization / Separation

Questions relate to 1(c) *What factors prevented placement of children in residential care into permanent family care?* 1(d) *What type of social service follow-up is provided to deinstitutionalized children, by whom and for how long?* 2(a) *Did the project provide a core package of services to help ensure that residential care is prevented when possible and that reunified and deinstitutionalized children and at-risk children remain in family care?*

8. What is your view on why children are currently placed in care outside of their family? (Probe for issues related to age, gender, social and economic family factors, physical or other health issues, etc.)
9. What is your view on factors preventing children currently living in residential care facilities from being placed in permanent family care?
10. In your opinion what facilitates family-based care?
11. What follow up is provided to children leaving institutions? Who provides it? For how long
 - a. In your opinion is this follow up effective? Why or why not?

E. Prevention / Family Strengthening

(Questions relate to Evaluation Question 2(c) *Have there been other unanticipated positive or negative results of the program?* 3(a) *Are households with children at risk of family separation stabilized and strengthened?* 3(b) *Were the relevant families chosen for inclusion in the project?*)

12. What factors make children at risk for separation from their families?
13. What services or supports are provided to households with children at-risk of family separation?
 - a. Which are the most effective? Why?

14. In your opinion, what skills and knowledge do caregivers need to be able to provide good care and protection for their children?
- Do caregivers in your district have these skills and knowledge?
 - What other skills do they need and who can help them obtain these skills?

F. Capacity

(Questions relate to Evaluation Question 5(a): *Do government authorities and state and non-state service providers have adequate attitude, knowledge and skills to build family resilience, involve, support, and protect children at the local level?*)

15. What are the main challenges that the district social work staff are facing?
- What are their main achievements? Probe: what is the average case load of social workers? About how long do child welfare staff stay in the job (retention rate)?
16. **[For KIs directly responsible for case management]** Please describe your role in case management of children in need of protection.
- Who are the key actors in implementing this case management system?
 - Can you please describe the current state of the system in terms of successfully managing cases?
 - What are the main factors in key successes and challenges? [Probe for numbers of children enrolled etc.]
17. What, if any training, have you received in delivery of alternative care programs? And who has provided this training? (Probe: phases of care: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)
18. Are there additional information, knowledge or skills that would assist you to undertake your own role within your organization/department/agency? (Probe for phases of reintegration: Identification of at-risk children/families; assessment; alternative care placement; permanent arrangements; ongoing supervision)

G. Coordination and collaboration

Questions relate to Evaluation Question 5 (b) *Have government authorities and state/non-state service providers adopted a joint approach to build family resilience, involve, support, and protect children at the local level?*

19. From your perspective, who are the key actors at the sub-national level whose responsibility it is to protect children? [Probe to get information on all sub-national players – commune, municipal, district, etc.]
- Why are these the most important actors? [Probe for mandate, capacity]
 - What are the main challenges that these actors are facing? What are their main achievements?
20. Does your department collaborate with other departments? In what ways?
- How would you characterize the collaboration?
21. Does your department collaborate with state or non-state service providers or other actors involved in protecting children at the local level?
- How would you characterize the collaboration?

H. Models and approaches for expansion, adaptation

(Refers to Evaluation Question 6(b) *Were any best practices or successful techniques institutionalized?*)

22. Are there practices, techniques or strategies that you expect will be particularly successful? Why?
23. What is your view on the work being done by P4EC in Moldova and the need for such a program?
- In what area are they making a major contribution?
 - In what areas could they improve?

ANNEX V: SOURCES OF INFORMATION

1. Survey:

A survey of social workers and community social assistants targeted by the project was conducted in Moldova. 300 respondents participated in this survey.

The survey consists of 8 sections.

- **Section 1: Demographics.** The goal of this section is to draw out basic demographic information, including gender, age, education, raion/community location, and years the social workers have been at the position.
- **Section 2: Opinion on supports of children.** This section asks a series of questions about the services that are available in the raion/community; whether such services are adequate and needed; and whether they can be improved.
- **Section 3: Opinions on coordination and collaboration and other service providers.** This section asks questions about different actors of the childcare and protection system. It also elicits responses on their rating and value assessment of the service providers.
- **Section 4: Social workers' capabilities and practices.** This section asks a series of questions about the social workers' assessment of the vulnerabilities of the families, the tools social workers employed, their work load, frequency of contact with the families, job responsibilities, and their self-assessment.
- **Section 5: Attitudes on residential care.** This section asks a series of questions about the social workers' attitude towards residential care, and their perception of community's support towards deinstitutionalization.
- **Section 6: Opinions on the current wellbeing of deinstitutionalized children.** This section asks a series of question about the adaptability of deinstitutionalized children, the challenges these children are facing, and how the social workers are working with families to help the children.
- **Section 7: Opinions on parental skills.** This sections ask a series of questions about the skills of caregivers and their assessments on the methods they are using to improve caregivers' skills.
- **Section 8: Policy and Legislation.** This section asks different questions about social's workers' opinion of existing policies and legislation related to childcare and protection in terms of adequacy, functionality, rating, etc. This section also assesses their knowledge and awareness of the resources available to them.

2. RCC data:

P4EC has transferred five datasets of the children in the 5 RCCs (Cahul, Ciniseuti, Hirbovat, Nisporenti, Visoca-Soroca) to the evaluation team. The RCC data contains the following information:

1. Basic demographic information: Gender, data of birth, data of entry to RCC, expected date of leaving RCC, district, addresses, reasons for living in RCC, siblings' information
2. Education: how well the child is doing in school, educational progress, how socially accepted and supported the child feels within the educational setting (by teachers and peers) and within the community and home, special support for children with disabilities,
3. Safety: the child's perception of safety at the institutions, schools, and communities, hardwork that can affect development of the child
4. Health: disability status, health status, registration with family doctors, frequency of checkup, receipt of treatment when necessary
5. Psychosocial component of well-being: child's self-care, social skills, negative emotions/aggressive behaviors, contact with family/parents/caregiver, frequency of contact with family/parents/caregiver, opinions about living in RCC

6. Family status: family status, parents' status, family issues, source of income

It's worth noting that the evaluation team only review the data of the child at baseline assessment (prior to deinstitutionalization). There were some information about the condition of family but they were incomplete or suggests that the assessments of these conditions were made after deinstitutionalization. For such cases, the data was not considered.

3. Knowledge Attitude and Practice (KAP) Survey:

P4EC conducted the Knowledge Attitude and Practice (KAP) survey in quarter I of 2015 to collect information on the level of knowledge, attitude and current practices of different professional groups on basic aspects of social protection of children and families. The objective was to identify gaps in knowledge and training needs and use this as an input to plan their in-service training. The target groups were: (1) community social workers, (2) specialists from territorial structures of social assistance, (3) personnel working with children and families in specialized social services, (4) members of the Commissions for the protection of the child in difficulty, (5) Psycho - Pedagogical Assistance Service employees, (6) social services managers, and (7) local government representatives responsible or involved in the protection of children and families in difficulty (vice presidents of the districts on social issues). In total 462 people participated in the survey.

4. List of Documents Reviewed

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Government Decision 1479 of 25 December 2008 on Minimum Standards of Quality for the Professional Parental Assistance Service (Romanian)

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Action Plan for Implementation of the Guidelines for Alternative Care of Children (English)

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P4EC Internal documents

Project proposal

Form 1: Evaluation of institutionalized child,

Form 2: Evaluation of Institutionalized Child Family Status,

Form 3: Evaluation of Community Service where the Child is Reintegrated,

Form 4: Studying Behavior,

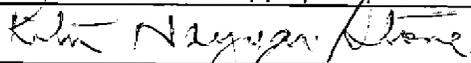
Form 5: Psychological Evaluation of an Institutionalized Child

ANNEX VI: CONFLICT OF INTEREST FORMS

Conflict of Interest

Name	Ritu Nayyar-Stone
Title	Senior Research Scientist
Organization	NORC at the University of Chicago
Evaluation Position?	<input checked="" type="checkbox"/> Team Leader <input type="checkbox"/> Team member
Evaluation Award Number (contract or other instrument)	GS-10F-0033M / AID-OAA-M-13-00013. Tasking N003
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	None
I have real or potential conflicts of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>If yes answered above, I disclose the following facts:</p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	7/16/2015

Conflict of Interest

Name	Mawadda Damon Gartner
Title	Performance Evaluator
Organization	NORC
Evaluation Position?	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> <u>Team member</u>
Evaluation Award Number <i>(contract or other instrument)</i>	GS-10F-0033M / AID-OAA-M-13-00013. Tasking N003
USAID Project(s) Evaluated <i>(Include project name(s), implementer name(s) and award number(s), if applicable)</i>	Good Governance in Georgia (G3), implemented by Management Systems International, RFTOP No. SOL-114-I-13-00001 Moldova Civil Society Strengthening Program (MCSSP), implemented by FHI 360, RFTOP No. SOL-121-14-000001
I have real or potential conflicts of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. 	

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	15 July 2015

Conflict of Interest

Name	Nancy Elizabeth “Beth” Bradford
Title	Subject Area Expert and Moldova Technical Lead
Organization	Maestral International LLC Consultant to NORC
Evaluation Position?	<input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member
Evaluation Award Number <i>(contract or other instrument)</i>	GS-10F-0033M / AID-OAA-M-13-00013. Tasking N003
USAID Project(s) Evaluated <i>(Include project name(s), implementer name(s) and award number(s), if applicable)</i>	No evaluation of directly funded USAID project. Evaluation of World Learning SPANS-016 funded project in Moldova – Every Child Moldova / P4EC
I have real or potential conflicts of interest to disclose.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>If yes answered above, I disclose the following facts:</p> <p><i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> <i>1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.</i> <i>2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.</i> <i>3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.</i> <i>4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.</i> <i>5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.</i> <i>6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.</i> 	<p>Note: As discussed with USAID/DCOF when I was selected for the evaluation, I was the mid-term and final evaluator on the previous P4EC USAID funded (through World Learning SPANS-016) project “Protecting children in Moldova from family separation, violence, abuse, neglect & exploitation”. In addition I have completed other work for the implementing organization including “EveryChild Moldova’s Programme Experience: Improving Children’s Lives through Deinstitutionalisation” in 2013 and evaluation of the EU funded, “Developing Short Break Foster Care Service for Children with Disabilities in the Republic of Moldova” in 2012. As a result I do have existing relationships with Partnerships for Every Child and knowledge of their program experience, but it will not affect my ability to provide objective input to the evaluation.</p>

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	15 July 2015

November 24, 2014

NORC at the University of Chicago
Attention: Andrey Pryjma, Director, Human Resources
55 East Monroe Street
Chicago, IL 60603

RE: NORC Consulting Agreement
Confirmation

Dear Mr. Pryjma:

As required, this letter is to certify that:

I am not a Board member of Terre des Hommes Foundation in Moldova (Tdh).

More than that, I am not involved (participate) in P4EC' project.

I do not have any personal/financial interest in evaluating positively the P4EC program.

I will be acting as an independent consultant and not a Terre des Hommes' employee during the assignment.

I also confirm that any change in the above mentioned facts will be immediately reported.

Sincerely yours,

Pelivan Veronica



ANNEX VII: CORRELATION TABLES

Table 1: RELATIONSHIPS Between Deinstitutionalized Children’s Adaptability in Raion/Community and the Challenges the Children and Caregivers Face

Variables of interest	Statistical significance
Children's adaptability and Challenges they face in the community	
Deinstitutionalized Children's adaptability in the community and Stigma from Community	**
Deinstitutionalized Children's adaptability in the community and Lack of access to school	***
Deinstitutionalized Children's adaptability in the community and Family risk factors	***
Deinstitutionalized Children's adaptability in the community and Lack of attachment between the child and family	***
Deinstitutionalized Children's adaptability in the community and Access to services	**

Note: * for p-value <0.01, ** for p-value <0.05, *** for p-value <0.001

Questions used:

- Q73: In general, are the children who have been deinstitutionalized in your raion/community adapting well?
Response options: *Mostly, Somewhat, and Not At All.*
- Q74: What, if any, are some particular challenges facing deinstitutionalized children and their caregivers? Please select all that apply
Response options: Yes, No .For each of the following 7 challenges: No challenges, Stigma from the community, lack of access to school, Family Risk factors, Attachment between the family and child is lacking, Access to services, Others.

Table 2: Relationships between Deinstitutionalized Children’ Characteristics And The Challenges The Children And Caregivers Face

Children's characteristics and Challenges they face in the community	Statistical Significance
Girls and Stigma from Community	*
Girls and Family risk factors	
Girls and Family risk factors	
Girls and Lack of attachment between the child and family	*
Girls and Access to services	*
Boys and Stigma from Community	
Boys and Lack of access to school	
Boys and Family risk factors	
Boys and Lack of attachment between the child and family	***
Boys and Access to services	***
Children with disabilities and Stigma from Community	*
Children with disabilities and Lack of access to school	**
Children with disabilities and Family risk factors	
Children with disabilities and Lack of attachment between the child and family	***
Children with disabilities and Access to services	
Children with learning disabilities and Stigma from Community	

Children's characteristics and Challenges they face in the community	Statistical Significance
Children with learning disabilities and Lack of access to school	*
Children with learning disabilities and Family risk factors	
Children with learning disabilities and Lack of attachment between the child and family	***
Children with learning disabilities and Access to services	
Children with chronic illnesses and Stigma from Community	
Children chronic illnesses and Lack of access to school	
Children with chronic illnesses and Family risk factors	
Children with chronic illnesses and Lack of attachment between the child and family	*
Children with chronic illnesses and Access to services	
Younger Children and Stigma from Community	
Younger Children and Lack of access to school	**
Younger Children and Family risk factors	
Younger Children and Lack of attachment between the child and family	
Younger Children and Access to services	
Older Children and Stigma from Community	
Older Children and Lack of access to school	*
Older Children and Family risk factors	*
Older Children and Lack of attachment between the child and family	
Older Children and Access to services	
Children who are of an ethnic minority and Stigma from Community	
Children who are of an ethnic minority and Lack of access to school	***
Children who are of an ethnic minority and Family risk factors	*
Children who are of an ethnic minority and Lack of attachment between the child and family	***
Children who are of an ethnic minority and Access to services	
Children from poor families and Stigma from Community	
Children from poor families and Lack of access to school	
Children from poor families and Family risk factors	*
Children from poor families and Lack of attachment between the child and family	*
Children from poor families and Access to services	***

Note: * for p-value <0.01, ** for p-value <0.05, *** for p-value <0.001

Questions used:

- Q74: what, if any, are some particular challenges facing deinstitutionalized children and their caregivers? Please select all that apply

Response options: Yes, No .For each of the following 7 challenges: No challenges, Stigma from the community, lack of access to school, Family Risk factors, Attachment between the family and child is lacking, Access to services, Other.

- Q76: Are there any categories of deinstitutionalized children who face more of the above challenges than others? Please select all that apply (Ask if question 74 was different to No challenges)

Response options: Yes, No .For each of the following 10 categories: Girls, Boys, Children with disabilities, Children with chronic illnesses, Younger children, Older children, Children who are of an ethnic minority, Children from poor families, other.

Table 3: Correlation Between Deinstitutionalized Children’s Adaptability in Raion/Community and Social Workers’ Perception of the Childcare and Protection System

Variables of interest	Statistical significance
Deinstitutionalized Children’s Adaptability And Social Workers’ Opinion Of The Adequacy Of The Policies And Legislation To Support The Child Protection System	
Deinstitutionalized Children’s Adaptability And Social Workers’ Perceptions Of The Functioning Of The Childcare And Protection System	***

Note: * for p-value <0.01, ** for p-value <0.05, *** for p-value <0.001

- Q73: In general, are the children who have been deinstitutionalized in your raion/community adapting well?
Response options: *Mostly, Somewhat, and Not At All.*
- Q87: Do you agree or disagree that existing policies and legislation are being adequately implemented to support the functioning of the child protection system?
Response options: Strongly agree, somewhat agree, somewhat disagree, strongly disagree.
- Q88: Do you agree or disagree that the child care and protection system functions as well as it is supposed to?
Response options: Strongly agree, somewhat agree, somewhat disagree, strongly disagree.

Table 3: Correlation between Social Workers’ Workload and Their Contact with Case Families

Variables of interest	Statistical Significance
Social Workers’ Case Number and Frequency of contact with the prevention case families with whom they work	***
Social Workers’ Case Number and Frequency of contact with the active case families with whom they work	
Social Workers’ Case Number and Frequency of contact with the monitoring case families with whom they work	***

Note: * for p-value <0.01, ** for p-value <0.05, *** for p-value <0.001

Questions used:

- Q53: How many activities cases do you currently have?

- Q54: On average, how often do you make contact with the prevention case families with whom you work?
Response options: *Daily, weekly, bi-weekly, monthly, every other month, less than every other month.*
- Q55: On average, how often do you make contact with the active case families with whom you work?
Response options: *Daily, weekly, bi-weekly, monthly, every other month, less than every other month*
- Q56: On average, how often do you make contact with the monitoring case families with whom you work?
Response options: *Daily, weekly, bi-weekly, monthly, every other month, less than every other month*